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THE RADICAL CURE OF HERNIA.

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Read before the California Northern District Medical Society.

Few subjects in the realm of surgical inquiry have commanded more persistent effort or a greater exercise of ingenuity than has the search for a safe and reliable plan for the permanent correction of the hernial condition. I say safe and reliable advisedly, for from a very early period, appliances were adjusted and operations done with indifferent success, for the correction of this perplexing lesion.

Until an ideal standard in wound treatment had been established, and the availability of buried sutures for the readjustment of anatomical relations had been demonstrated, the fundamental conditions of the radical cure for hernia were impossible of fulfillment. Beginning with the period when asepticism eliminated wound infection as the chief danger in surgical procedures, rapid advances are noted in this direction. Excision of the sac, and suture of the pillars *en masse* were attended with encouraging results, but the percentage of relapses was such as to throw discredit upon the plan, and it was not until a comparatively recent date, that, what seems now an approach to perfection of *technique*, had been attained.

Bassini, in 1888, publicly announced the method which has made his name familiar to us all, but it failed for a time to attract general attention. For several years thereafter, the term, radical cure for hernia, was generally regarded as a misnomer. Such was the sentiment proclaimed by a well known surgeon, before the American Surgical Association, in 1890. Referring to the frequent relapses occurring after various operations by reputable authorities, he said: "These observations will, without doubt, be duplicated in the cases yet to be traced, and go to strengthen the conviction, that all methods of radical cure will be found unsatisfactory." It is needless to add that this judgment has been reversed by its author, who now, with all modern teachers, recognizes in the operative treatment of hernia an accredited surgical procedure.

The problem as stated by Halsted,[1] "is to close a rent in the abdominal wall, and to provide for the safe transmission of the spermatic cord."

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[1] American Journal of Medical Sciences, July, 1895.

The conditions upon which a solution of the above problem must depend, were previously laid down by Coley,[2] as follows: "First, a mortality either *nil* or not greater than that associated with the condition prior to operation. Second, a reasonable hope of success either as regards cure or relief."

In support of these assertions, it seems superfluous to offer evidence or argument, Many operators avow that the number of relapses after a period of from two to five years is insignificant in uncomplicated cases. It might be contended that these periods are insufficient for an estimate of the permanancy of cure. It has, however, been shown by Coley (*loc. cit.*), that nearly all relapses after the earlier and less perfect operative methods occurred within one year after the operation, hence it is apparent that the longer period of immunity from recurrence speaks much for the value of later procedures.

As regards risk entailed by the operation, Marcy, in his recent elaborate work, refers to over three thousand operative cases which were attended by a mortality of less than 1 per cent. It will accordingly be assumed, for the purpose of this paper, that the operation is competent, and that the surgeon may now offer to the truss wearer, relief from discomfort, and escape from danger in a great majority of cases.

The contraindications for the operation are obvious, as the step would be improper in advanced age, in those cases where the hernia is of unusual size, or complicated by incarceration of long standing, and where organic disease of other organs has become well established. The procedure is especially well adapted to the laboring man who is materially embarrassed by the presence of a truss, and in constant danger of its becoming displaced at critical epochs. This is equally true of persons in all the walks of life, wherein, from the size of the aperture, or on account of an adherent strip of omentum, a truss fails to afford relief and becomes an intolerable burden. Finally, resort to operative treatment is well nigh imperative in those cases where there is an undescended testis accompanied as it invariably is by a congenital hernial protrusion. The great probability of malignancy affecting the testis in later life is recognized as a positive menace; while relief for the hernia through a mechanical appliance is practically impossible.

That the herniæ of children are now and then cured by mechanical appliances is undoubtedly true. but this fact does not materially affect the availability of operative interference in this class of cases; on the other hand, it should be strongly advocated for the following reasons: First, the moral effect of what is virtually a deformity, exerts a depressing influence upon the mental and physical development of the individual. Second, in a very large number of instances, it is impossible to provide the child with a well fitting and safe apparatus. This is particularly true of children who are reared in the tenement quarter of great cities. Furthermore, it is but a rational inference that early repair of the defect in the abdominal wall prior to the full development of the parts must offer a better outlook, than do operations upon adults, where the deviation from normal conditions has become well established.

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[2] Ibid., May, 1895.

The operations which bear the names of their originators, Bassini and Halsted, seem to have been adopted by the more frequent operators of the present day. While many modifications have been suggested, yet the principles laid down by these authorities are so closely adhered to, that the name of no other teacher need be considered essential in this connection. Moreover, it has been contended with apparent reason, that the distinctions which are insisted upon by the respective followers of Bassini and Halsted are unimportant. Although recognizing the fact that the *technique* of these operations is familiar to most of us, I shall briefly describe the former, and casually refer to those features which distinguish it from the latter.

The incision for Bassini's operation begins over the internal inguinal ring, and is carried down above the external ring to the upper scrotal folds. The fascia of the external oblique muscle having been exposed, a director is passed from the external to the internal ring, and the intercolumnar fibers are divided upon it. This exposes the cord and accompanying vessels, closely attached to which will be found the hernial sac. The latter structure is carefully separated, the dissection being carried as high up as the internal ring; it should then be opened and inspected, that its contents, if any there be, may be returned to the abdominal cavity without molestation. The sac should then be clamped close to the internal ring and removed. Before the clamps are loosened the sac, or more properly the peritoneum, should be carefully closed with a fine continuous suture.

The cord and vessels are next dissected from their underlying attachments, and lifted out of the operative wound by a hook in the hands of a skilled assistant. The conjoined tendon, consisting of the united fasciæ of the internal oblique and transversalis muscles, will now be found forming the upper or internal pillar of the hernial opening. This is grasped by a clamp and drawn downwards and outwards, until it meets the deep expansion of Poupart's ligament. To this it is finally anchored by a row of carefully adjusted sutures, from three to five in number. The structures forming the cord are now laid upon this newly-made floor; the fascia of the external oblique is brought over it, and in a similar manner attached to the more superficial fibers of Poupart's ligament. The integument is then closed in the usual manner to complete the operation.

The variations from the above procedure, which have been held by Halsted to be of sufficient importance to distinguish his operation from that of Bassini, are as follows: In dealing with the deep layers of the abdominal wall, he carries the incision about one inch above the internal abdominal ring, through the fibers of the internal oblique and transversalis muscles. The sac having been isolated and removed, the cord is carried upward to the angle of the elongated incision. A new point of emergence for the cord from the abdominal cavity is thereby established. The hernial opening is then closed, as in the first step of Bassini's operation, by attaching the deeper layers of abdominal muscles to the under surface of Poupart's ligament. The floor of the new canal is now further reinforced by the fascia of the external oblique, which is carried beneath the cord, instead of over it, and attached to Poupart's ligament.

At this point the size of the cord is lessened by ligating and cutting away a portion of the accompanying veins. This step, although regarded by Halsted as important, is admitted by him, and claimed by others, to be attended with considerable risk, several cases having been reported where atrophy of the testis has resulted from this interruption of the circulation. It is probable, however, that when the accompanying veins are especially cumbersome, they may be advantageously dealt with in this manner. The cord is finally dropped into the wound and covered only by the integument.

It is interesting to note that both of the foregoing procedures were announced by their originators at about the same time, and, although Bassini's claim to priority is probably sustained by the records, it is equally true that Halsted's announcement was the result of independent research.

In my own work I have fallen into the way of choosing the Halsted method in those cases where the deep abdominal structures are attenuated and unreliable. Under such circumstances, I fancy a more substantial barrier is formed by combining all the abdominal layers.

Quite recently Kocher has announced a modification, which, with added experience, may find approval. After having separated the sac, he uncovers the external oblique fascia for a distance of about one inch above the internal abdominal ring; at this point a small incision is made in the fascia of the external muscle. Through this he passes a pair of clamp forceps, the points of which are made to emerge at the upper angle of the original wound. The fundus of the sac is grasped by the forceps and drawn upward toward the button-hole incision in the external oblique. The neck of the sac is firmly stitched to the fascia, near the button-hole, and the balance cut away. The main advantage argued by Kocher for this scheme is that, in case suppuration occurs in the operative wound, peritoneal infection is less liable to follow.

In this connection the name of another surgeon is so intimately associated with the *technique* of this operation as to demand more than a passing mention. I refer here to Dr. H. O. Marcy, of Boston, whose observations upon the great value of kangaroo tendon, as a material for sutures, together with his method of applying them, has given him an enviable notoriety.

I can recall no surgical exigency where the necessity for a perfect material for buried sutures is greater than in the one under consideration. The requirements are for a suture possessing a minimum of size, and a maximum of strength. Furthermore, it must be readily capable of sterilization, non-irritating, and sufficiently durable to insure support for from eight to twelve weeks. Silk was originally employed by Bassini, but it has so often given rise to stitch abcesses and other unfortunate incidents, that it has come to be regarded by many with suspicion. Silver wire has been resorted to in this connection, but for the same objections as are advanced above its claims are not well sustained. Dr. Marcy finds that kangaroo tendon is well preserved when buried in human tissues for a period of from ten to twelve weeks, which is about the time required for firm union of the tissues here involved. The experience of Coley adds much weight to the claims of Marcy, he having recorded primary union in one hundred and nine, out of one hundred and twelve cases in which kangaroo tendon was employed.

The Marcy stitch is so generally understood as to demand no lengthy description. After considerable experience with it, I am impressed with its superiority, and in future shall employ it in preference to the interrupted suture which is generally in vogue.

I wish now to call attention to an important structural peculiarity which materially affects left-sided hernias, and which, when present, demands intelligent and dextrous management. It often occurs that the sac of a left-sided hernia is composed in part of that segment of the peritoneum which contains the insertion of the mesocolon of the sigmoid flexure. Such being the case, the sigmoid flexure will be found to be anchored firmly to the sac. I suspect that this attachment has not infrequently been mistaken for an ordinary adhesion, and torn across without regard to consequences. The only proper method of dealing with this complication is carefully to separate the mesocolon from the bowel. This will leave a small area of the bowel unprotected by the peritoneum, which fault should be immediately corrected by bringing the edges of the peritoneum together with a few fine Lembert stitches. The gut may then safely be returned to the abdomen, and the sac removed.

Finally, I am deeply impressed with the fact that in this undertaking there rests upon the surgeon great personal responsibility. The patient's condition prior to operation frequently involves no immediate risk, and the inconveniences from which he seeks relief are not wholly a bar to comfortable existence. Moreover, the attainment of an ideal result depends upon the production of a wound that is unusually complex in its *technique*.

The operator is, therefore, held to a stricter accountability than in ordinary routine work. This suggests the necessity for absolute ascepticity. Suppuration occurring in a hernial wound is a most humiliating circumstance, as it not only renders failure practically inevitable, but increases greatly the danger to life. Hence, it follows naturally that without full confidence in one's ability to establish and to maintain surgical cleanliness the operation should not be undertaken.

426½ J street.

THROAT AFFECTIONS IN THE ERUPTIVE FEVERS.

By J. Dennis Arnold, M.A., M.D., San Francisco, Cal.

The indictment has frequently been urged against specialism that it fosters in its followers a tendency to have eyes only for local disease, and to be blind to the constitutional maladies, of which local disease is often only a manifestation. It is further said that because of this fault, specialists are very prone to neglect the invaluable aids of general treatment.

Granting that such a tendency exists, and is to be combated, it is just as true that general practitioners are inclined to make light of local lesions that obtain during the course of constitutional disease, and to neglect means of special treatment for such lesions. The argument that if a local disease is absolutely recognized as the regional expression of a systemic poison—when the system is rid of the poison the local affection will also disappear—is valid as far as it goes, but it fails to take cognizance of the fact that the local lesion may leave such anatomical or structural change in its former site as to impair the function of the part.

Surely, therefore, if there exist, over and above measures directed against the general disease, such means as may arrest structural change in the special region attacked, it would be gross negligence not to attempt the benefit of such means. When, for instance, a case of iritis is brought to the practitioner, and he has thoroughly convinced himself that the iritis is of syphilitic origin, he is surely not content with giving the patient mercury or iodide of potassium because he knows that these are antidotes for the specific poison, and that when the poison shall have been eliminated the inflammation of the iris will cease; the practitioner will also use such topical measures as he knows may prevent adhesions and preserve the integrity of the eye until he has made an impression upon the disease with his constitutional drugs. In like manner, if a syphilitic ulcer upon the palate of his patient threatens perforation, and consequent impairment of voice, he will most assuredly employ the best means at hand to combat the local disease at the same time that he plies the system with anti-specific remedies. But in the case of some of the febrile exanthemata, where local affections of the air passages are just as pronounced and dangerous as in venereal disease, they rarely receive the same amount of attention, and, therefor, it often happens that grave injury to voice or hearing, which might have been prevented by proper local treatment, is carried through life.

A simple catarrh of certain regions of the respiratory passages is developed during the early stage of all eruptive fevers, but it frequently happens that in scarlatina, smallpox, typhus, and sometimes even in measles, the throat has to bear the brunt of the morbid process, or, rather, becomes the theater of the most pronounced local manifestation of the systemic poison. In scarlatina, especially, the throat symptoms are of grave import, and the presence or absence of implication of this region has supplied the basis for the most generally used specific names of the different varieties of this disease, as scarlatina anginosa, and scarlatina *sine* angina.

In measles, the affection of the mucous surfaces is usually limited to the larynx, trachea and bronchi, and it is only in exceptional cases that the pharynx and nares are invaded. It manifests itself as an acute catarrh, which often precedes the appearance of the skin eruption by one or two days. This condition is in some cases accompanied by an edema of the arytenoids or epiglottis, and a stenosis of the glottis thereby occasioned may necessitate tracheotomy. In a large majority of cases, however, the inflammation in the larynx runs an uncomplicated course *pari-passu* with the eruption upon the surface of the body, and rarely persists after it. Croupous, or necrotic interstitial exudation, is fortunately of rare occurrence, and is only met with in those severe cases where a lobular pneumonia supervenes during the course of measles, which fact would seem to make it probable that the irritation of the laryngeal mucous membrane, from contact with the expectorated secretions of the diseased lung, is an important etiological factor in this complication.

Of far greater moment is the throat trouble of scarlet fever, and in many cases it forms the principal source of danger to the patient, persisting for one or two weeks after complete subsidence of the rash. It may be taken as the rule that the inflammation of the fauces will make its appearance almost simultaneously with the prodromic fever that precedes the eruption by from 12 to 24 hours. The tonsils and arches of the palate become intensely red, swollen and painful, and the elongated, inflamed papillæ, give to the tongue an appearance well described by the term "strawberry tongue." By these symptoms by far the greater number of scarlet fever cases are first recognized as such, and the condition of the throat is often a more reliable point for the differentiation of this disease from measles than is the character of the skin eruption.

The inflammatory process is particularly virulent upon the tonsils, which, on the second or third day, show points of superficial ulceration; these coalesce, and the whole pharynx soon becomes covered with a thick, grayish exudation which closely resembles the false membrane of diphtheria. It is not uncommon that even in the first stage of the fever, the inflammation extends downwards into the larynx—the epiglottis and false cords being the seat of election in this region. The tonsils are usually so enlarged and painful that a satisfactory examination of the deeper parts with the mirror is often impossible, but when this is practicable the epiglottis will appear of a deep-red color, somewhat swollen, and with numerous points of excoriation upon its free edges. The ventricular bands look like long, flabby tumors that almost meet in the median line, completely cover the true cords, and obliterate the ventricles. As I have stated above, extensive ulceration is exceptional here, its favorite seat being the tonsils and the adenoid tissues in the posterior nares. The structural changes left after the disease has run its course are always most pronounced in the pharynx. Adherence of the soft palate to the posterior wall of the pharynx, and occlusion of the mouths of the Eustachian tubes by cicatrization are the most common remnants of anginose scarlatina.

In variola, the development of pustules upon the mucous surfaces of the throat is nearly constant. Wagner found that among 170 cases of smallpox patients examined laryngoscopically, in 144, true pustules existed in the pharynx or larynx, and in all the remaining cases, save one, an active catarrh with the ecchymosed spots scattered over the membrane. The pustule often becomes the nucleus of a virulent ulcer which may cause considerable destruction of tissue in these regions which do not well resist disintegration. The soft palate and epiglottis are the structures most frequently attacked by such ulceration. I have seen two cases in which the velum was completely destroyed.

A catarrhal condition of the throat is always a concomitant of typhoid fever, but ulceration and breaking down of the tissue is seldom observed, whilst in the true typhus extensive ulceration with perichondritis and necrosis of the larynx is a frequent complication. Nearly 80 per cent. of all typhus patients develop edema of the glottis during the course of their disease.

In view, therefore, of the important part played by the throat symptoms during the course of all the febrile exanthemata, it is evident that they should not be neglected as to active topical treatment, when it is probable such measures will be of avail in retarding or altering the disease as manifested upon the mucous surfaces. Of course the local therapy can in no wise replace a constitutional treatment which, from the nature of these diseases, must be chiefly tonic and supporting.

In the laryngeal and tracheal catarrh of measles nothing more is necessary than inhalation of astringent vapors. In scarlatina, excision of the tonsils in the early stage, a measure recommended by Browne, is one that I think should be adopted in all cases where these glands project beyond the pillars of the fauces. The additional space thereby gained for deglutition and respiration when the whole pharynx shall have become tumefied and swollen, will go far to prevent the occurrence of those distressing croupy symptoms which so often arise in anginose scarlatina. As soon as the fauces become inflamed they should be frequently sprayed with a chlorate of potassium solution that has been slightly carbolized. The pharynx and larynx are to be carefully watched for the first appearance of erosions, which must be immediately touched with a strong solution of chloride of zinc or copper sulphate. In short, the indications for treatment of ulceration in the whole class of diseases under consideration are just the same as those in the catarrhal or specific ulceration: Firstly, to arrest the process of disintegration; and secondly, to establish by strong impression upon the morbid tissues a process of repair.

To enter largely into the region of topical medication is, however, somewhat beyond the scope of this paper, whose object is only to fix attention on the fact that in the eruptive fevers the throat affection is so grave as to demand special measures for its treatment, measures which shall be principally directed against the loss of substance and impairment of function in the parts.

530 Sutter street.

A NEW BIVALVE SPECULUM.

By Wallace A. Briggs, M.D., Sacramento, Cal.

Read before the Sacramento Society for Medical Improvement.

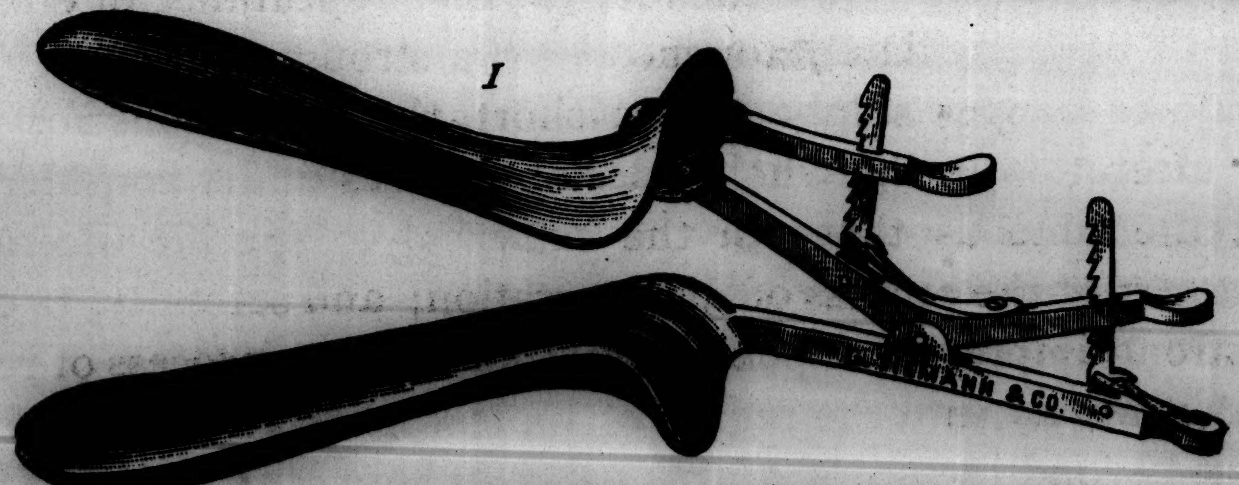
Somewhat more than two years ago Messrs. Tiemann & Co. made, at my direction, a bivalve vaginal speculum which, after prolonged trial, I am convinced possesses advantages sufficient to warrant its formal presentation to the profession.

The blades, in form, are very much like those of the Cusco speculum, but may be made to suit the fancy of the individual operator. They are joined on one (the right) side only, and are separated by two levers, which are caught automatically and held firmly by ratchets.

The accompanying illustrations show the speculum in different positions when adapted for the various purposes for which it can be employed: (1) Shows the speculum when ready for ordinary use. (2) For deposit of powders. (3) As Cusco's speculum. (4) As Brewer's, with short superior blade. (5) Arranged for cleansing.

The speculum possesses the following advantages:

1. It may be operated much more rapidly than the ordinary speculum. The ratchets catch automatically, and may be disengaged instantaneously by slight pressure.
2. It may be used as a Cusco, or, by separating the blades slightly at the base, as a Brewer.
3. It works equally well in the dorsal and in the Sims position.
4. It may be so adjusted when in position, by dropping the point of the upper blade, as greatly to facilitate the deposition of powders in the vagina.
5. It may be adjusted to the vaginal walls and to the introitus more perfectly than the ordinary speculum.
6. It may be cleansed with the utmost ease and thoroughness.



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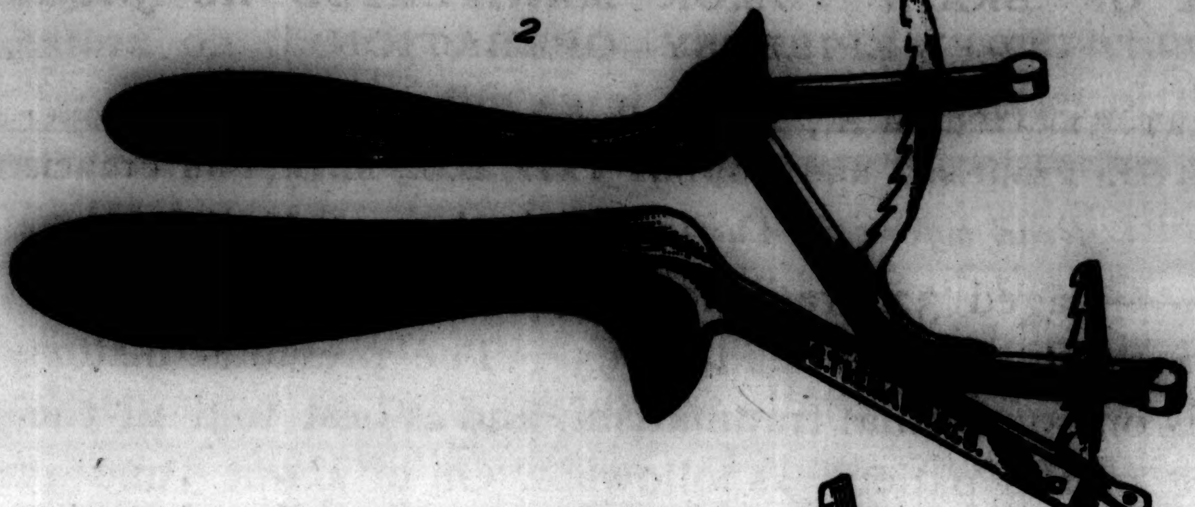

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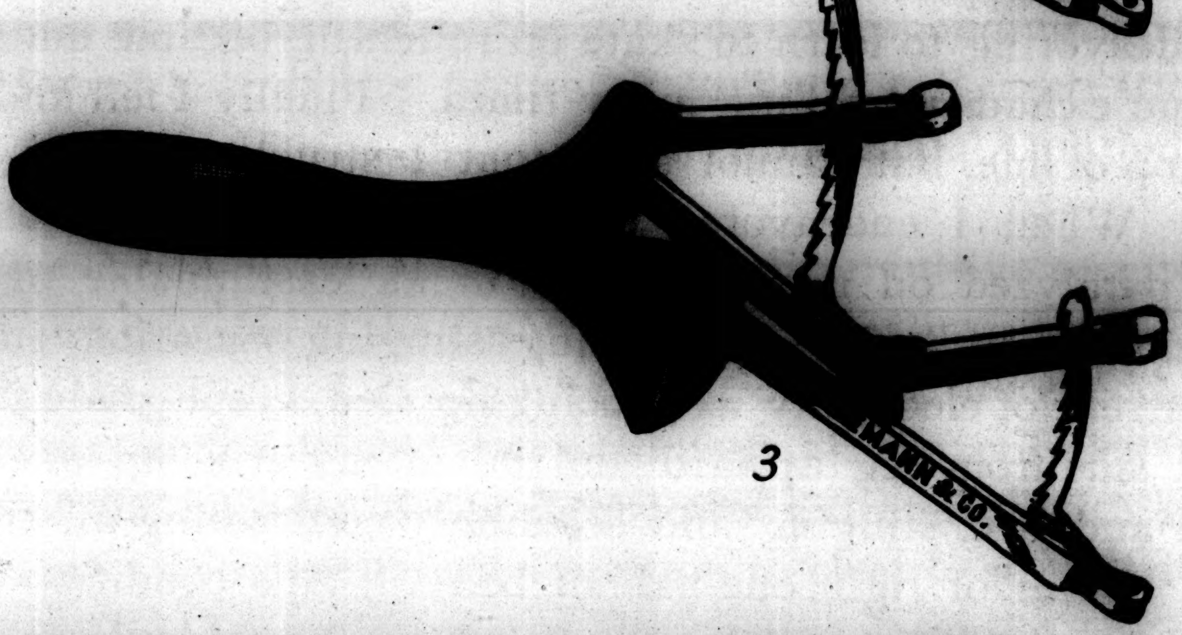

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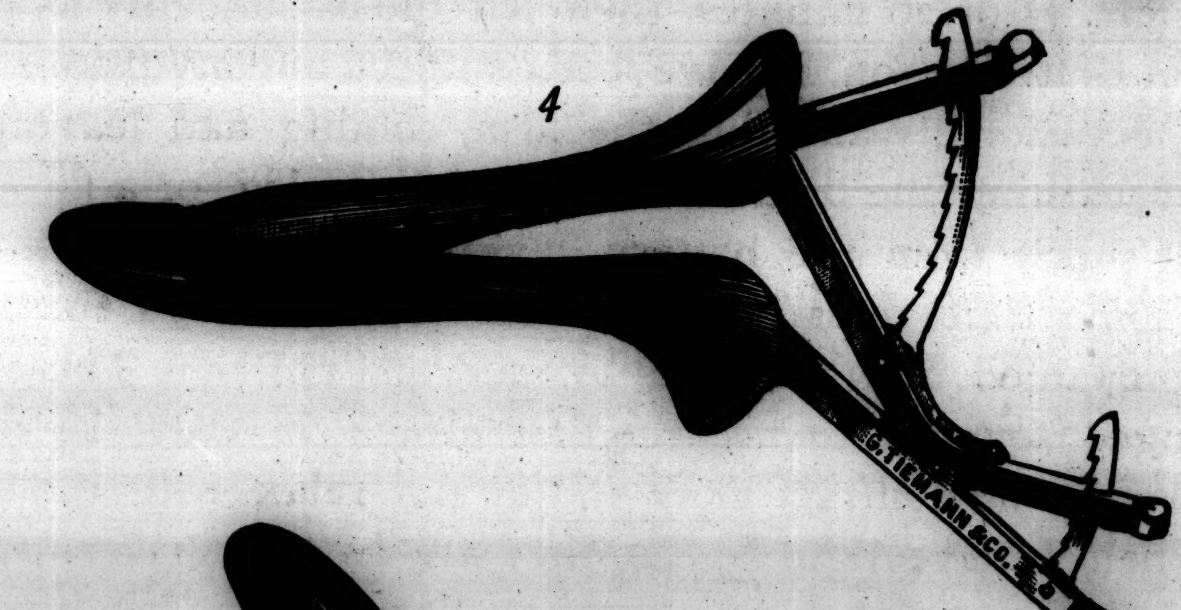

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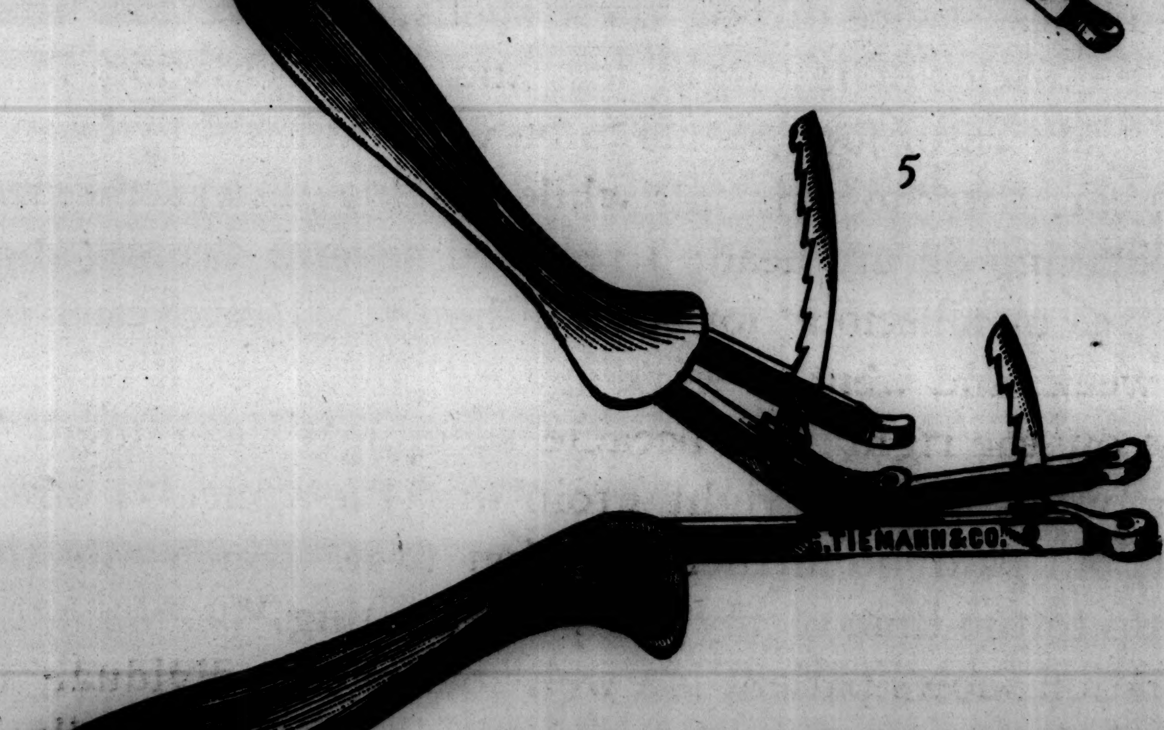

A CASE OF BRAIN TUMOR MANIFESTED AS JACKSONIAN EPILEPSY—OPERATION.

By **Albert Abrams**, M.A., M.D., Professor of Pathology Cooper Medical College, San Francisco, and **Dudley Tait**, B.S., M.D., San Francisco, Cal.

Read before the California Academy of Medicine.

H. F——, aged 32, was referred to Dr. Abrams by Dr. Allen, of San Francisco, on May 22d, 1895. The previous history of the patient is one of cranial traumatism, and is best told in the graphic language of the patient, as follows: "On or about June 4th, 1892, while endeavoring to learn to skate on rollers, I became much overheated and exhausted, falling many times. Finally I fell and a man fell on top of me, but cannot state that I struck my head in any manner. When I endeavored to rise I was, as nearly as I can explain, paralyzed on my right side, or at least unable to control that portion of my body. A creeping, stinging sensation, such as a strong current of electricity were being applied, crept gradually over my right side from leg upward and down my arm, up one-half of my head and face, stinging and seemingly contracting all the muscles and nerves of right one-half of body. This condition continued for some 15 or 20 minutes, then left me as suddenly as it came on. From that time on, I have been subject to convulsions of the right leg, occasionally affecting the arm, coming and leaving suddenly, but warning me by a sort of jerk of the leg, or a flash, such as a light shock from the battery, making me a little sick at the stomach, some times more than others. Most always these spells were accompanied and followed by nervous chills. These spells have changed somewhat since the first attack, in that the muscles seem to cramp and contract more and do not relax until the spell is over. When I have light spells, they are as the former. I have lost consciousness twice during these spells. I have lost the use of some of the muscles of my right leg, and the circulation in same is very poor. My right foot seems to be very difficult to keep warm. About a year prior to this fall while skating, I was thrown from a wagon, striking on my head; I received several bruises about the head and was unconscious for several hours. I recovered in a few days or a week, and went to work again. But I recall to mind that my big toe on the right foot became seemingly dead to all feeling for some months, and my right groin was the same. I often wondered at it, but paid no further attention to it. Such was the state of affairs up to the time of my fall while skating."

Examination shows patient is a well nourished individual; his gait is characteristically spastic on the right side. The patella tendon reflex and cremaster reflex on right side are exaggerated. Foot clonus is exaggerated. There is paresis of the muscles and paralysis of the hallux on the right side. Idiomuscular contraction can be elicited by percussion of the sural and tibial muscles of the right lower extremity. The electrical reactions are quantitatively but not qualitatively changed. Measurements show atrophy of the muscles of the right lower extremity, particularly those of the leg. Tactile sensation and temperature sense are diminished, while the muscular sense and sensation to pain are nowise altered. There is no implication of any of the cranial nerves. Percussion of the scalp elicits a sensation of tenderness on the left side corresponding to the course of the lower half of the fissure of Rolando. Examination of the viscera, blood, and urine, shows nothing abnormal. Ophthalmoscopic examination negative.

Recapitulation of symptoms.—Localized convulsive seizures beginning in the muscles of the right leg, sometimes involving the corresponding arm, attended as a rule by consciousness, preceded by sensory phenomena and followed by weakness of the muscles involved. Paresis of the muscles of the right lower extremity, with spasmodic phenomena. No degenerative reaction to electric stimulation.

Diagnosis.—An irritative and destructive lesion of the cortex, in the rolandic region, probably in the vicinity of the leg center, of a slow though progressive character. Dr. J. O. Hirschfelder made a similar diagnosis at an independent examination of the patient.

Treatment.—Although there was no specific history, the patient underwent a thorough inunction course of 3 weeks, with apparent benefit; the paroxysms became infrequent, the gait improved, and the muscular power of the affected extremity increased. This transitory improvement was followed by a recurrence and exaggeration of symptoms which induced the patient to consent to an operation by Dr. Dudley Tait.

Operation—January 1, 1896.—On shaving the head no scars were found. The fissure of Rolando was accurately determined by Lucas Championnière's and Thane's methods combined, and its limits nicked on the skull. A ¾-inch trephine was applied at the upper ¼ of the line corresponding to the fissure of Rolando, the pin being placed ¼ of an inch directly posterior to the line. The skull at this spot was found to be very thick and hard, but the button of bone showed no abnormalities. The dura was slightly adherent at the upper border of the trephine opening. No pulsation could be discerned. The dura was now opened by a vertical incision, and a dark-reddish, hard mass bulged markedly through it. By means of four more buttons of bone radiating from the first opening, and the free use of the rongeur, an opening was made measuring 1¼ x 1¾ inches.

The tumor could then be distinctly mapped out; it was situated between the hemispheres, pushing downward and laterally the left hemisphere in the region of the calloso-marginal sulcus. Exploration with the finger showed absence of adhesions except at the upper border where the tumor was strongly adherent to the dura. Venous hemorrhage proved very troublesome after this exploration, although not alarming. Hot tampons and compresses were used, but without apparent effect. The patient showed signs of collapse immediately after the first attempt to circumscribe the tumor with the finger, but was revived, thanks to the kind and clever assistance of Dr. C. H. Steele. Enucleation of the tumor was performed with comparative ease, a small portion however, remaining, on account of the dense adhesions to the dura in the median line. The resulting cavity was filled with tampons in view of controlling the venous hemorrhage, and partly checked it. Collapse returned, however. immediately after the removal of the tumor, and death ensued shortly afterwards, notwithstanding all efforts of resuscitation.

Necropsy.—At the necropsy, four hours after death, a careful examination demonstrated the integrity of the superior longitudinal sinus. The tumor, a spindle-celled fibro-sarcoma, originated at a point of the dura contiguous to the sinus. The adjacent hemisphere presented nothing of importance.

Remarks.—This case presents several points of interest to the surgeon. The precision with which the tumor was located and attacked thoroughly compensates for the fatal result of the surgical interference. It is our opinion that death was due to shock. No large vessels were injured; the superior longitudinal sinus was found intact at the necropsy, and the effects of venous hemorrhage were very probably controlled by the saline injections and the cardiac stimulants. Moreover, it was evident that each exploration or manipulation of the tumor, and its ultimate removal, gave rise to immediate signs of collapse. The value of the tampon in controlling hemorrhage during and after the removal of neoplasms of the brain has been made very evident by the brilliant researches of Horsley. In the present case, however, owing to the vascular structure of the tumor, the tampons proved of very limited benefit.

THE ROENTGEN OR X RAYS IN MEDICINE AND SURGERY.

By W. N. Sherman, Ph.D., M.D., Merced, Cal.

Read before the San Joaquin Valley Medical Society.

Probably no scientific discovery has been received with greater interest than that of Prof. Wm. Roentgen. It is a marvellous discovery of modern times, and of great interest and importance to the medical profession. Roentgen attracted the attention of the world when he announced his ability to photograph the bones of the human body through flesh. The discovery also closes an interesting chapter in the history of electricity, viz: the dealing of high tension electric discharges through rarefied gases.

Since the time of Faraday, experimenters have investigated the strange phenomena resulting from passing high tension electric currents through vacua and rarefied gases. Prof. Crookes and others have presented papers to various scientific bodies, giving results of their remarkable experiments on electrical discharges through vacua. Among all these various and remarkable results, the behavior of the discharge emanating from the negative pole, the so-called cathode, has been the most remarkable.

Crookes was probably the first to conduct exhaustive experiments on the discharges in very high vacua, and to connect the state of the attenuated gases with Faraday's hypothetical radiant matter. At ordinary atmospheric pressure, an electrical discharge of high tension takes place, usually, in the form of sparks, between the charged terminals or as a continuous spray from a brush or other form of electrode. With a diminished air pressure, such as is present in exhausted tubes or other vacua, the discharge between the terminals becomes continuous and diffuse, resulting in illumination of the tube. A familiar experiment of this nature is produced by the Geisler tubes and a good static machine. At a much higher pressure, approximating one-millioneth of an atmosphere the character of the luminous discharge in the tube is changed and the illumination greatly diminished. A dark space is seen to surround the negative pole, or cathode, in the bulb, the depth of the space being influenced by the degree of exhaustion in the bulb, and the path of the discharge is no longer in line with the positive and negative poles, but seems to be independent of the positive or anode.

The highly exhausted glass bulbs used in these experiments are called Crookes' tubes, and must be carefully and skilfully made to obtain the best results. It is supposed that the so-called radiant matter within the tube consists of molecules projected at a high velocity from the negative pole, in lines normal to its surface. These glass bulbs should have disc terminals of aluminum, attached to platinum wire, for connection with the energizing agent. A large Ruhmkorff induction coil, or a good Holtz static machine, are the proper agents with which to connect the tube, as it requires a current of very high electro-motive force. The streams of luminous active matter projected by electric force from the negative or cathode terminal, are the so-called cathode rays, and when they strike the walls of the glass bulb, they produce fluorescence. These cathode rays are deflected by magnetic force, but are not influenced by prisms, or lenses of glass, or other substance. Ordinarily, radiant matter moves in straight lines.

In addition to the cathode rays, which produce the heat and fluorescent light when projected against the glass of the vacuum tube, wherever they strike it, there is another form of radiant matter or energy generated there, and called the Roentgen or X rays. They are so called because their character is not known. They, like the cathode rays, produce fluorescence, but are *not* influenced by magnetic action. It has been discovered that the effect of the bombardment, within the Crookes' tube, was not limited by the walls of the tube, the effects are noticeable *outside* the tube. It has been observed that fluorescence outside the tube takes place or is effected on other fluorescent substances, and this fact has suggested the methods of experiment by the wizard, Edison, who is gradually reducing, as well as developing, this discovery to a practical solution.

The cathode, or the X ray, is able to produce vibrations of the ether outside the vacuum tube. These vibrations again create fluorescence, and also produce or precipitate chemical changes in photographic plates. These rays are also capable of penetrating substances according to their density, and thus reaching and changing the chemical elements of the photographic plate. Let us remember that the X rays, while very similar and closely related to the cathode rays, are not the same; that they are produced or proceed from a point where the cathode ray impinges upon the wall of the tube, and further, that the cathode ray may be deflected by magnetic influence, while the X rays are not deflected. This new ray is said by the author to be a longitudinal vibration of the ether; and if so, it is of great scientific importance.

These rays penetrate substances according to their density. A paper screen, washed with platino-cyanide of barium, lights up brilliantly and fluoresces when turned toward the discharge tube. All bodies are transparent to this unknown influence, but in various degrees. It is to be hoped that these shadow pictures, or radiographs of interior living organisms, will soon be perfected so as to show us the various parts in different shades, according to the absorptive power of each part. Who shall say, but that the time is near when one may stand before a screen and have photographed to the eye the secret, and at present invisible, parts of the living body? Like the phonograph, this wonderful electrical apparatus may be carried from door to door soliciting custom from those who believe themselves the victims of some organic or functional disease. Let us hope, however, that its legitimate use may be confined to men of science, for the benefit of all humanity.

Already we are enabled to diagnose certain diseases and deformities of the bones, and to locate foreign substances in them. We find that many universities and individual scientists are experimenting with the X ray, and certainly some great good must develop from it. Possibly the half has not been told as to the powers of this marvelous energy. It has been shown that the soft tissues make some impression on the plate. It seems probable, that with a more intimate knowledge of these rays, some means of controlling them, as is the case with all other known rays, may be found. It is possible the varying changes of the soft tissues in disease and health may be shown. Thus cirrhosis of the liver, Bright's disease, lung cavities, and other conditions may be diagnosed.

It would not surprise me at any moment to hear of some such startling declaration as that we may see through and into the human body and view its various organs, as though the body were transparent. Or upon a fluorescent screen an instantaneous shadow may be projected of the various organs of the body, of renal, cystic or biliary calculi, fractures and injuries to bones, foreign bodies in the alimentary canal, in muscles or bone, internal tumors, pregnancy, clots upon the brain, etc. These summaries are but hints at the possibilities of this great discovery.

ASEPTOLIN.

By A. L. LENGFELD, M.D., Professor of Materia Medica and Medical Chemistry, Medical Department, University of California, San Francisco.

Read before the California Academy of Medicine.

As Dr. Edson in his article (*Medical Record*, February 8, 1896,) recommending aseptolin for the treatment of phthisis pulmonalis plainly states that he does not desire to have his discovery "classed with that of a proprietary remedy," and furthermore, that "the new agent can be used as freely as any compound or combination of the pharmacopeia," it is fair to assume that he invites criticism, and is willing to accept suggested improvements.

Most physicians are not chemists, and Dr. Edson is evidently no exception to this general rule; he may, therefore, be pardoned for having admitted into his article a so-called chemical report which is full of errors and absurdities, and is either intentionally or accidentally misleading and false. If Dr. Edson were not known as a man of high professional attainments and high standing we might be led to believe that he had joined the great army of nostrum vendors in their efforts to secure wealth from and through the medical profession.

As Dr. Edson plainly states "that there is no reason why a competent chemist should not make it," and furthermore, that "it is not very difficult to make, provided one has the apparatus and is sufficiently careful," it is difficult to understand why there should be so much ambiguity in describing the process, the methods, and the chemicals used, and why specially designed and extravagantly expensive chemical apparatus (*vide* his letter in the *Examiner*, February 28, 1896), should be necessary.

The composition of aseptolin is as follows:

Water (H_2O)	97.2411 per cent.
Phenol (C_6H_5OH)	2.7401 per cent.
Pilocarpin-Phenyl-Hydroxide ($C_{11}H_{16}N_2O_2$ OH C_6H_5)	0.0188 per cent.
Total	100.00 per cent.

—*Medical Record.*

A careful reading of chemist Mott's report and Dr. Edson's remarks upon it, and a careful sifting out of all that is equivocal in the formula, shows that "aseptolin" is practically a solution containing approximately 0.02 per cent. (0.0188) of pilocarpin-phenyl-hydroxide, commonly called pilocarpin phenate, in a 2.75 per cent. solution of pure phenol. Pilocarpin-phenyl-hydroxide is not such a difficult chemical to prepare—the phenates as a class are staple compounds, and are easily prepared. The phenates of K, Na, NH_4 Hg quinine, cocaine, and others are known and used in medicine, being obtained either by direct union of the base with phenol, or by double decomposition, and pilocarpin-phenyl-hydroxide can be so prepared without the aid of "apparatus specially imported from Germany." By heating phenol (C_6H_5OH) with the alkaloid pilocarpine ($C_{11}H_{16}N_2O_2$) (not $C_6H_5N_2O_2$, as given by chemist Mott) in the proportion of their combining values (not in the proportion given by chemist Mott), at a temperature not exceeding 100° C., or by adding an alcoholic solution of phenol (C_6H_5OH) to an alcoholic solution of pilocarpin ($C_{11}H_{16}N_2O_2$) at a temperature not exceeding 100° C., the salt is readily obtained. Dissolving this salt so obtained in a 2.75 per cent. solution of phenol gives, without the aid of special apparatus and without any special skill, the now famous aseptolin.

As in one part of Dr. Edson's paper the salt is described as a "colorless crystalline salt," while in the very next column we are told "that uncrystalized pilocarpin-phenyl-hydroxide separates out," and, as Dr. Edson admits, refusing pharmacists a supply of the new salt, and has failed to present samples of it, or even a description to any medical, pharmaceutical, or chemical society, or journal, or even to the daily press, it is fair to assume that neither chemist Mott nor Dr. Edson have ever isolated the salt, and that neither one knows whether their aseptolin is what they claim, viz., a solution of pilocarpin-phenyl-hydroxide in phenated water, or merely a solution of the alkaloid pilocarpin in the same.

So little do they apparently know of the character of that "new compound" which chemist Mott says, "you (Dr. Edson) have, after laborious research and experiment, produced," that even in giving "its composition as deduced by calculation," wrong statements are made. If pilocarpin-phenyl-hydroxide is, as is claimed, a chemical compound, its composition deduced by calculation is: Pilocarpin, 68.89; phenol, 31.11—100.00; and *not* pilocarpin, 53.92; phenol, 46.08—100.00, the proportions given by chemist Mott. Of course, if they merely have a mixture, the proportions can be anything they desire, even those given above.

However, before many weeks (and without the aid of Dr. Edson and his chemists) pilocarpin-phenyl-hydroxide will be an article of commerce as easily obtainable as are the other salts of this alkaloid. As Dr. Edson admits that "the formula is by no means complicated," and that while "the other ingredients are at hand, the salt alone is as yet not procurable." It necessarily follows that when it is obtainable, any pharmacist will be able to prepare the aseptolin as scientifically and as accurately as it is to-day by the doctor and his experienced chemists. The many misleading and false statements, as well as the complicated methods of Chemist Mott, and the extraordinarily expensive special apparatus of Dr. Edson, will, therefore, fade away, and only the glamour of successful charlatanry remain.

As much stress is laid upon the necessity of using only the purest phenol, and as a so-called process is given for preparing their "highly purified phenol," a few words about this chemical may not be uninteresting. Phenol-phenyl-hydroxide, or carbolic acid, as it is called, the formula of which is $C_6 H_5 OH$, and not $C_6 H_7 O$, as so repeatedly written by Chemist Mott, can be obtained in a state of absolute purity from various manufacturers, prepared either directly by the usual processes from coal tar, or prepared scientifically from benzine ($C_6 H_5 H$, phenyl-hydride), or from aniline oil ($C_6 H_5 NH_2$, phenyl-amine). C. P. phenol, free from para-cresol and other impurities, is an article of commerce, and the process given by Chemist Mott will not purify it from traces of these substances, unless, perhaps, the temperature is very carefully watched and regulated, a point which he very carefully neglects to mention. "To reject the first 10 per cent. so condensed, utilizing the remainder, with the exception of the last 10 per cent., which is likewise rejected," is a process identical with, and probably copied from, the directions given in the U. S. P. for the preparation of distilled water, and, while of great importance in the manufacture of this simple pharmacopeial remedy, is practically valueless for the purification of phenol.

Chemist Mott says: "Having obtained this 'highly purified phenol,' it is diluted with distilled water until the percentage of phenol is reduced to exactly 2.75 per cent. This is introduced into glass-stoppered receivers (retorts, or flasks, I suppose, were meant), which have been thoroughly cleansed with boiling water. In the receiver is placed the right proportion of the alkaloid, so that as the phenol distills over and condenses, it immediately combines with the pilocapin in the production of the fluid. The temperature of the receiver is kept * * * sufficiently high to insure the desired union."

Why this crude method should be followed, instead of the simpler one of preparing a pilocarpin-phenyl-hydroxide, as already described, and merely dissolving it in the 2.75 per cent. phenol solution, is difficult to answer, but it probably explains the trouble they have had in preparing "aseptolin" of a uniform composition, and of an absolutely colorless physical appearance. It is probable, however, that the expert (?) chemist who suggested this method merely remembered the general rule, that alkaloids were less soluble than their salts, and were more soluble in hot, H_2 O, than in cold. He, therefore, suggested the plan of placing the alkaloid in the receiver, allowing the distillate to come over at a comparatively high temperature, so as to permit the phenol to combine with the alkaloid pilocarpin under apparently the most favorable conditions, gradually converting it into a phenate, to be immediately dissolved in the excess of phenated water.

In this process, as well as in their various formulæ, Chemist Mott and Dr. Edson have displayed an inexcusable ignorance regarding the properties of the chemicals they are dealing with, and as their reports are full of misstatements and errors, which could have been easily avoided or rectified by simple reference to standard authorities, are we not justified in believing that the same gross carelessness governs their work, their results, and their product; and that when once the salt is obtainable, more careful, more conscientious, although, perhaps, not as prominent workers, will furnish a product better and more scientifically and accurately prepared than that "aseptolin" with which they now supply us?

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DEPARTMENTS.

OBSTETRICS, GYNECOLOGY AND PEDIATRICS.

By WALLACE A. BRIGGS, M.D., Sacramento, Cal., and
WM. FITCH CHENEY, B.A., M.D., Adjunct to the Chair of Obstetrics and Diseases of Women and Children, Cooper Medical College, San Francisco, Cal.

The Use of Cocaine for Whooping-Cough.—WELLS and CARRE believe that pertussis is due to a specific microbe which settles, by preference, in the respiratory mucous membrane and there fabricates some virus, which, taken into the circulation, acts as an irritant poison to the respiratory and vagal centers. The best method of treatment would therefore be some agent which would destroy the microbe and counteract the effects of the poison; but such a drug is unknown. The best we can do is to look for some drug that will have a paralyzing action on the vagal (vomiting) and respiratory centers, and lessen the sensibility of the peripheral terminations of the different nerves from the respiratory and gastric mucous membranes to the medulla. Such a drug we have in cocaine. If used locally, by swabbing or spraying the throat, the nerve endings of the stomach are still left untouched, and vomiting is not controlled; the writers, therefore, advise the use of cocaine internally, in watery solution; the dose based on the standard of a one-grain dose for an adult, three times a day. They treated 323 cases in this way, and never saw any marked evil effects follow the use of the drug. The improvement, on the other hand, was soon manifest and the duration of the disease much shortened.—*Lancet*, June 8, 1895.

Laparotomy on a New-Born Infant.—Cases of laparotomy in the new-born are very rare, especially for umbilical hernia. In the literature of the subject, since the year 1836, only 31 cases had been noted previous to one just reported by DR. N. P. MARJVNTSCHIK, of Kiew, Russia. The infant was a full-term child, normal in every respect except for an apple-shaped tumor in the middle of the abdominal wall, extending from the ensiform process to the navel—8 centimeters long and 6 centimeters broad. Operation was done by PROF. TSCHERNOW, about thirty hours after birth. The tumor was found to contain part of the liver, omentum, and intestines; these were carefully replaced, the edges of the abdominal wall freshened and then brought together, the sutures passing through all the tissues from peritoneum to skin. The infant died on the fifth day after the operation, autopsy showing the cause of death to be peritonitis and acute gastro-colitis. The writer reviews the 31 cases previously reported, of which seven died. He concludes that operation should be done in all cases if the child seems capable of life, and that it must be undertaken as early as possible. The method of operation must depend upon the size of the defect in the abdominal wall and the number of adhesions; but the most correct method is laparotomy.—*Centralblatt f. Gynäkologie.*

Gauze Tamponade of Cervix for Hyperemesis Gravidarum.—F. A. KEHRER, of Heidelberg, reports a case of hyperemesis gravidarum, for which he tried successively bromide of soda, tincture of nux vomica, cocain solution, and painting the cervix with nitrate of silver—all without success. Regulation of the diet, of the bowels, of the rest at night, and other hygienic measures were all resorted to, but the woman steadily grew worse, until it was decided to empty the uterus. In the thirteenth week, therefore, the cervix was packed with iodoform gauze, with the woman in Sims' position. The vomiting immediately decreased, and in 24 hours ceased entirely. Abortion did not take place, and the woman went on for another 12 weeks perfectly well. Then vomiting began again as violently as before, and in the twenty-sixth week the gauze tamponade of the cervix was repeated. Once more the vomiting was greatly relieved, though not entirely stopped. A third time, in the thirtieth week, vomiting became so severe that the cervical tamponade was used, and following this the vomiting again ceased entirely. In the thirty-third week, the vomiting recurred, and this time Kehrer decided, as the child was viable, to terminate the pregnancy. He did so; obtained a living child that thrived, and the mother made a good recovery.—*Centralblatt f. Gynäkologie*, April 11, 1896.

Puerperal Self-infection.—DR. CHARLES JEWETT reviews the recent literature regarding the question of puerperal self-infection by means of the vaginal secretion, and also presents the views of numerous prominent teachers of obstetrics as to the usefulness of the *ante-partum* douche. He reaches the following conclusions: There is no clinical proof that puerperal infection can occur from normal vaginal secretions, and all childbed infection in women previously healthy is by contact, the causative agent being conveyed to the patient from without. Prophylactic vaginal disinfection as a routine measure is unnecessary, and even in skilled hands is probably injurious. A purulent vaginal secretion, however, exposes the woman to puerperal infection, and in the presence of such discharges, at the beginning of labor, the vagina should be rendered as nearly sterile as possible; but concentrated antiseptic solutions should not be used, and the process should be conducted with the least possible mechanical injury to the mucous surfaces.—*American Gynecological and Obstetrical Journal*, April, 1896.

Local Treatment of Puerperal Endometritis.—In a most interesting review of "Recent Bacteriological Investigations Concerning the Nature of Puerperal Fever," DR. WM. T. LUSK emphasizes the fact that the treatment employed may do more harm than good. Especially where the streptococcus is the cause of sepsis, great caution must be exercised. In the great proportion of cases not interfered with, the process is and remains a localized one. The injection of a weak microbicide solution will not kill the streptococcus germ. A strong solution acts only upon the surface, where it likewise kills the tissues, washes away the thrombi, and when the douches are repeated at short intervals, paralyzes the muscular structures. But the enemy does not long remain upon the surface—rather at an early stage it has already penetrated the underlying tissues. Therefore, it is argued, the curette should be employed to scrape away the entire decidua. "Doubtless," says Lusk, "there are patients who survive this practice." But as a rule the curette thus employed destroys the barier of leucocytes which nature has thrown up between the infected decidua and the deeper tissues, and so opens the door to the enemy. Mild cases are frequently converted by this process into virulent ones.—*American Journal of Obstetrics and Diseases of Women and Children*, March, 1896.

Morphine Injections for Ectopic Pregnancy.—PROCHOWNIK, of Hamburg, reports that since the year 1883, he has seen 90 cases of ectopic pregnancy, and has six times employed the method of treatment recommended by von Winckel, viz.: injections of morphine into the sac. Four of these cases were treated successfully, through the vagina, by direct injection of morphine, without preliminary aspiration of the sac; 3 recovered smoothly in 5 to 8 weeks, but the fourth developed an abscess that discharged into the rectum, and was cured only after drainage was established through the vagina. The fifth case was injected through the abdominal wall. Two days later sepsis manifested itself. For this, celiotomy was performed, which showed that a coil of intestine adherent to the sac had been perforated by the injection. Under abdominal drainage the woman recovered. In the sixth case, a hematoma had already formed. He asks, after his observations, that operation shall not be at once resorted to, but an attempt first made to bring about resorption, by killing the embryo with morphine injection. Injection should be made primarily, not after aspiration. Furthermore, injection should not be made after the third month, nor if any symptom of abortion has occurred. It should always be done through the vagina, never through the abdominal wall. In the discussion that followed this paper, WORTH said that the weak point in Prochownik's reasoning, lies in the fact that after the injection we never know whether the ovum is dead or still alive. FEHLING remarked that the cases of so-called recovery by this method, are deceptions in diagnosis; if not, the injection causes an artificial abortion, and the case must then be operated upon. GOTTSCHALK thought that even after death of the embryo, the resorption of the ovum can prove dangerous, as he learned from a case he saw, where, finally, the sac suppurated and broke through into the bladder. In closing the discussion, Prochownik admitted that he had succeeded better with operative measures than with conservative, yet he did not propose, in the future, to give up conservatism. Through our knowledge of tubal abortion, in all its phases, we are forced away from the view that ectopic pregnancy is such a malignant thing as heretofore conceived, and with increasing anatomical knowledge, we are compelled to adopt more conservative measures.—*Centralblatt f. Gynäkologie.*

SURGERY AND ANATOMY.

By T. W. HUNTINGTON, B.A., M.D., Surgeon Southern Pacific Company's Hospital, Sacramento, Cal., and

GEO. B. SOMERS, M.D., San Francisco, Cal.

Intestinal Obstruction Associated with Displaced Kidney.—KIDD details 7 cases of intestinal obstruction due to fecal accumulation, where the kidney was found to be displaced or movable. He thinks that the cause of the obstruction was mechanical pressure of the kidney on the lumen of the large intestine, though the sympathetic nerves may have some share in the cause, either through inhibition of peristalsis or over stimulation of peristalsis, either of which would result in stasis of the contents of the colon.—*Lancet*, December 21, 1895.

Results of Orchotomy for Enlarged Prostate.—C. MANSELL MOULLIN presents his experiences with 12 cases. Two died shortly after the operation, one on the ninth day, and the other on the fifth. In two cases there was a peculiar form of traumatic delirium, which set in a day or two after the operation and caused the gravest anxiety. It was not due to septic complication, or to anemia, but the symptoms were those of intense depression, with delirium. Both these recovered. In all these cases, even to the one that died on the fifth day, there was a diminution of obstruction. The improvement cannot be accounted for by rest in bed or the other palliative measures, for these measures were given thorough trial before operation. In all but one case voluntary power of micturition returned, and the residual urine fell below two ounces. Altogether the results were encouraging. The author suggests further that the removal of a single testicle may be found to do almost as well as the removal of both. He also alludes to the possibility of substituting for orchotomy, double ligature and resection of the vasa deferentia.—*Lancet.*

Intestinal Resection.—In summing up his experience with a number of cases of resection of the intestines, HERBERT W. ALLINGHAM arrives at the following conclusions: "Stricture of the large intestine must not be resected when the intestine about the stricture is distended with feces. Stricture of the small intestine may be resected even when the gut is distended, for the feces are liquid." Accordingly, the author resorts to a colotomy near the site of the stricture when it is in the large intestine, so as to thoroughly empty the parts of their contents. When this has been effected, and the patient has recovered in general health, a second operation should be performed, which consists in freeing the artificial mass from its attachment to the belly wall and resecting it and the stricture in one piece.—*Medical Press and Circular*, February 5, 1896.

The Management of Cases Immediately Following Operations.—SIR THORNLEY STOKER sums up an article on this subject as follows: "If I may reduce to formulæ the matters I have referred to, I would put them thus: (1) That the tendency to prolong operations must be carefully guarded against, as it is a grave cause of danger. (2) That in the treatment of shock and vomiting following operation we get no help from the stomach, and must rely on the rectum as its substitute. (3) That heat, alcohol, and opiates are our best remedies; and that the latter are well borne, and must be intelligently used to their full effect. (4) That drugs of the class ordinarily used to check vomiting are of little or no use in the cases under consideration. (5) That ice does not relieve thirst, and does harm by introducing water into the stomach, and so provoking vomiting.—*British Medical Journal*, December 7, 1895.

The Value of the Cocainization of the Nasal Mucous Membranes before and during Surgical Anesthesia.—ALFRED G. GERSTER, A. D. MAYER, and C. THEOBALD (*Annals of Surgery*), have confirmed, by observations upon a series of 100 cases, Rosenberg's statement that the most dangerous factor in the phenomena of anesthesia is due to an interference with the respiratory organs producing an irregularity of the heart's action. The irregularity is due, not only to mechanical interference with the entrance and expulsion of air, but also, and principally, to the influence on the pneumogastric nerve and the respiratory center in the medulla, produced reflexly by irritation of the branches of the trigeminal nerve in the nasal mucous membrane. Experiments on animals showed that by diminishing the perceptive capacity of the terminal nerves of the mucous membranes, there was less interference with the respiration and circulation. The following procedure is accordingly recommended: The nose is freed from mucus and 2 centigrammes of a 10 per cent. solution of cocain are sprayed into each nostril. Two minutes later a second application of 1 centigramme is made to each nostril, and anesthesia is begun. The application is renewed every half hour during the continuance of the administration of the anesthetic, and before removing the patient a final spraying is administered. The advantages of the method are: less feeling of suffocation owing to absence of odor of anesthetic; short or absent stage of excitement; vomiting rare; sickness following anesthesia does not occur.—*Philadelphia Polyclinic*, February 8, 1896.

Form and Position of the Kidneys.—From original researches, PROFESSOR CUNNINGHAM gives the following description: "In every case and on both sides there is on the anterior surface a point of maximum convexity, a place where the kidney substance is raised in the form of a marked prominence or bulging, which may slowly rise from all sides to a blunt summit, as is usually the case in the left kidney, or which may extend across the anterior surface in the form of a rounded ridge, as happens more commonly in the case of the right kidney. Above and below this eminence the anterior surface falls away toward each extremity, in the form of an inclined plane of greater or less obliquity. These impressed districts indicate pressure exercised on the anterior surface of the kidney in two directions, and the intervening eminence is the result of this counter-pressure. Upon the upper inclined plane of the anterior surface of the left kidney are placed the suprarenal capsule, the stomach, and the spleen. These exercise a downward and a backward pressure. Upon the inferior inclined surface of the left kidney, the counter-pressure is produced by the intestinal canal, which presses, as a rule, upward and backward. On the right side, the upper inclined surface is occupied by the liver, whilst in contact with the lower inclined area is the colon. In many cases the colic or inferior sloping surface presents a high degree of obliquity." In commenting on this description, **Kendal Franks** calls attention to the fact that on the right side we thus have two forces acting on the kidney: one acting from above, presses the kidney downward and backward; the other, acting from below, presses the organ upward and backward. The resultant of these forces will be a force acting almost directly backward, holding the kidney in the position it usually occupies.—*British Medical Journal.*

Wandering Kidneys—Movable and Floating.—"The normal kidney has a limited range of movement. When it transcends this it is said to wander. Wandering kidneys are of two kinds—movable and floating. There are at least fifty movable to one floating. By many the floating kidney is believed to be nearly always congenital. It may or may not give rise to symptoms. The movable kidney, on the contrary, is more often extremely painful, and a source of great irritation." "Wandering kidneys may be mistaken for tumors of the spleen, liver, omentum, and ovary." "Careful search should always be made for wandering kidney in conditions in which vomiting constitutes crises."—*Medical Record*, January 4, 1896. **Albarran** (*Annales des Maladies Org. Gen.-urin*) presents the most important paper published up to this time upon the subject. He notes that the symptoms bear no definite relations to the degree of mobility of the organ. Some patients exhibit serious conditions with a kidney but slightly movable, whilst others experience almost no discomfort with a kidney that is really floating. The symptoms may be classed under three principal headings: (1) Pain. (2) Nervous symptoms. (3) Digestive disturbances. These are frequently associated in the same individual. The pain varies from a slight feeling of discomfort in the hypochondrium to almost constant pain; or again, it may occur in paroxysms. The pain frequently resembles that of nephritic colic. Reflex disturbances, such as vomiting and prostration, are common. Albarran believes that the cause of the pain, and especially the crises of pain, is a twist or compression of the ureter. The nervous symptoms vary from slight disturbances to neurasthenia or hysteria. The digestive disturbances are referred to mechanical compression of the intestine by the displaced kidney, or to dragging of the duodenum. Three local conditions may be associated with movable kidney. They are hydro-nephrosis, pyelo-nephritis, pyo-neparosis. In the treatment, most excellent results are obtained from nephrorraphy. Massage and apparatus for retaining the kidney in position are also used. The gravity of movable kidney is undoubted. The operation of nephrorraphy is a very safe one, and its results have been very successful.—*Boston Medical and Surgical Journal*, December 5, 1895.

OPHTHALMOLOGY, OTOLOGY AND LARYNGOLOGY.

By Wm. Ellery Briggs, M.D., Sacramento, Cal.

Autoscopy of the Larynx and Trachea.—Dr. M. Thorner describes the new instrument invented by Dr. Kirstein, of Berlin, for the examination of the air passages without the aid of the laryngeal mirror—called the autoscope. It consists of three parts, viz.: the spatula, the sliding hood, and the handle. The examination is made as follows: The physician stands before the patient, who is seated on a chair with the neck inclined slightly forward. The electric light contained in the handle is illuminated, and the instrument is introduced into the mouth the same as an ordinary tongue depressor. In this position the pharynx may be inspected. Next the spatula is gently pushed backward, and the handle gradually elevated, while a firmer pressure, directed downward and forward, is being made on the base of the tongue. During the whole procedure the physician must look steadily along the well-illuminated instrument to inspect the various parts of the epiglottis, the posterior wall of the pharynx, the arytenoid cartilages, and the pyriform sinuses. For inspection of the larynx and the trachea the handle is still more elevated, so that the sliding hood rests against the upper incisors, carefully avoiding pressing against the teeth, but using more pressure on the base of the tongue. There are some obstacles to the manipulation in some patients. Some throats have to become used to the manipulation, while it is impossible to elevate the epiglottis sufficiently in some patients. For such cases a specially constructed spatula is used. The instruments for operating through the autoscope must be especially constructed for this purpose. The inventor believes this instrument is as valuable for the specialist as the laryngoscope. This manipulation requires practice, but the results are surprising to the observer who has examined the larynx exclusively with mirrors. It will prove a valuable adjunct to laryngoscopy for one who knows when to use the one and when to apply the other.—*Journal American Medical Association*, February 8, 1896.

Etiology of Deviations of the Nasal Septum.—Dr. John O. Roe says the causes of deviations of the nasal septum are predisposing and exciting. The former are struma, tuberculosis, syphilis, rachitis and cretinism, and racial characteristics. Civilized people suffer more from deviations than do primitive races. The aquiline type of nose is frequently thus affected. Exciting causes include disease of the septum or other parts of the nose, and defective development. The vomer is formed from two laminæ with intervening cartilage, in which ossification begins as early as the sixth week of fetal life, and proceeds from behind forward, and the coalescence of the laminæ is completed by the third year. Some times this does not happen at all. The slightest irregularity of development leading to hypertrophy at any point, tends to push the plate over to the other side. A similar effect is produced by hypertrophy of the cavernous tissue of the septum as well as of the inferior turbinated. Where deviation occurs, the turbinated bodies on the larger side are generally hypertrophied. This is the effect and not the cause of the septal condition, the hypertrophy being caused by the excessive amount of air passing through the over-patent nostril. Anterior deviations are caused by chronic turgescence of the mucosa, growths, results of operations, dislocation of the triangular cartilage, and flattened alæ. Trauma is also a powerful factor in deviations. It is more frequent in males of all ages, and callus generally forms on the convex side. Intranasal disease, producing crusts, etc., and causing the patient to blow the nose frequently with the same hand, or to pick one side of the nose, acts in the same way.—*American Medico-Surgical Bulletin*, May 23, 1896.

Operation for Deviation of the Nasal Septum.—DR. A. W. WATSON, in a paper on the operation for deviation of the nasal septum, says, that to be successful, the resiliency of the cartilage must be broken up. Many procedures fail because they do not provide for the reduction of the amount of tissue necessary to convert a bent septum into a straight one. This should be done by removing a portion of the tissue in the general line of deviation. If the latter is horizontal we must take out an elliptical piece, gradually convergent at either end; if vertical, a wedge-shaped piece, with apex above, extending as high as possible, with its base near that of the septum, where it may be joined by a horizontal incision. The excised portion should always include the protruding angle. The mucous membrane must not be cut on the concave side, as it helps to hold the edges. The incision must, therefore, be made on the convex side, followed, if necessary, by the use of the crushing forceps. A second necessary feature is the proper retention of the parts. The author prefers a flat pin with a ring head covered with rubber tubing, inserted from the concave side, passing diagonally through to the other side, across the vertical incision, if existing, and then back again into the septum until the head lies on the latter, care being taken to avoid deflection in the opposite direction. In this way both sides are left free for cleansing and respiration. Padding of the pin head prevents ulceration, and it may be worn for three weeks or more without discomfort.—*American Medico-Surgical Bulletin*, May 23, 1896.

The Treatment of Iritis.—MR. HENRY JULER says that the first canon in the treatment of iritis from whatever cause is a negative one—to do no harm—by the use of astringents. If there be any doubt about the diagnosis, the proper course is to let the astringents wait and to prescribe a mydriatic for a few days until the truth declare itself. Many eyes are irreparably injured by the neglect of this simple precaution. The second step in the treatment of any case of plastic iritis is to aim at complete dilatation of the pupil. This is of paramount importance and should be done immediately the condition is recognized. This is to prevent the formation of plastic adhesions to the lens capsule, or to endeavor to break them down if recently formed, to keep the inflamed iris at rest, and to diminish the amount of plastic exudate by contracting the blood-vessels. A 1 per cent. solution of the sulphate of atropine is the best mydriatic. This should be dropped into the palpebral sac every 3 or 4 hours. If adhesions have already formed and are recent, it is well to use the mydriatic every hour for 6 consecutive hours. To prevent constitutional effects the patient should press the puncta-lachrymalia for a few minutes after each instillation, so as to prevent the drug passing down the nasal duct. The next indication is to relieve the local pain and congestion. Cocain hydro-chlorate in 2 per cent. solution works well in most cases. Hot fomentations come next as a valuable adjunct to these drugs. Local blood letting may be resorted to if pain still persists. Three leeches, with an artificial Heurtelouf leech, give great relief. In persistent cases paracentesis of the anterior chamber often causes immediate relief. If these remedies do not relieve the pain we must resort to sedatives. The third important indication is the treatment of any constitutional dyscrasia. The constitutional treatment must be made appropriate to whether the cause is found to be secondary or some later stage of syphilis, to rheumatism, to gout, or some other cause.—*Medical Press and Circular*, May 13, 1896.

DERMATOLOGY, SYPHILIS AND VENEREAL DISEASES.

The Parasitic Treatment of Eczema.—In the discussion of a paper bearing the above title, which was presented before the American Dermatological Association, at its recent meeting, by ZEISLER, of Chicago, a free expression was indulged in by the members, and their views are certainly entitled to considerable attention. It is a well known fact that one of England's dermatologists has held this opinion for some time. It is tolerably certain that Malcom Morris has some good reason for his view, and whether the paper of Zeisler will start any further thinking or not, is yet to be seen. White and Bowen, of Boston, Fox and Jackson, of New York, with Hartzell, of Philadelphia, did not believe that the disease was of parasitic origin. Fordyce, of New York, thought some instances may be of purely parasitic origin, while Elliot, of New York, had believed for years that a large proportion of cases were thus caused; while Bulkley, of New York, and Shepherd, of Montreal, believed that all cases of eczema were of parasitic origin. Robinson, of New York, did not consider that there was such a disease—a clinical entity—as eczema, and believed that the time was coming when the different manifestations of what we now term eczema would be divided with distinct names, as had been done formerly when ringworm, scabies, and other affections had been differentiated. Wigglesworth, of Boston, believed that the reader of the paper had done more than he thought by bringing the subject out at this time, and while leaning somewhat to the parasitic side of the discussion, he was not so positive as some of the other members. In closing the remarks, Zeisler felt that he was supported in his parasitic views.—*Philadelphia Polyclinic.*

Death Eighteen Hours After the Introduction of a Bougie Into the Urethra. MULLER (*Centralblatt f. die Krankheiten der Harn, und Sexual-Organe*) has reported the case of a man, 38 years old, with a history of gonorrhea in youth, who came under observation on account of some difficulty in micturition. He had previously been treated for stricture of the urethra. The urine was turbid, and passed in a small stream. A diagnosis of vesical catarrh, with moderate stricture of the urethra, was made, and to determine the degree of narrowing, metallic sounds were employed. A No. 21 conical instrument, with a long curve, was first gently introduced, with due antiseptic precautions, and an impassible obstruction encountered in the membranous urethra. With still greater care, a No. 23 sound was next used, but also without success. The examination was unattended with pain, and but little blood was lost. A prescription containing uva ursa and sodium bicarbonate was given, and the patient sent home. Three or four hours after the manipulations, and immediately upon taking his medicine, the patient was seized with vomiting and diarrhea, followed by chills, restlessness, general prostration, pains in the chest and in the sacral region, and excessive thirst. Eighteen hours after the use of the bougies the patient died, amid symptoms of cardiac failure. Upon *post-mortem* examination, the heart was found to be slightly fatty and the lungs edematous. There existed cloudy swelling of liver, spleen, and kidneys. Portions of kidney were put aside for histological examination, to determine if nephritis existed, but were inadvertently lost. The ureters and pelves of the kidneys presented no abnormality. A tight circular stricture was found involving the membranous urethra, and, close by, several diverticular depressions of the urethral mucous membrane, one of which appeared to have been recently eroded. Copious greenish pus escaped from the prostate gland. The mucous membrane of the bladder was in a catarrhal state; the viscus contained a small amount of turbid urine. The opinion is expressed that the fatal issue in the case reported is to be attributed to an acute nephritis, induced, perhaps, through the introduction of pus from the prostate through the erosion in the urethra.—*Medical News.*

MATERIA MEDICA AND THERAPEUTICS.

By WM. WATT KERR, M.A., M.B., C.M., Professor of Clinical Medicine, University of California, San Francisco.

Lactophenin as an Antipyretic.—DR. SENFFT, of Wiesbaden, contradicts the opinion of DR. KOEBL that lactophenin causes collapse when administered in proper doses. He claims that lactophenin is the safest and most satisfactory antipyretic that can be given to children, and that Dr. Koebl's unfortunate experience was due to the fact that the dose was absurdly large.—*American Therapist*, January, 1896.

Ferratin.—DR. J. S. PEREKHAN relates (*Chicago Medical Recorder*, January, 1896), his experience with ferratin in the treatment of malarial poisoning and anemia. The malarial case was of the distressing neuralgic type, and had been treated for six weeks with quinine and tonics of iron and arsenic, with but little benefit. At the end of this time ferratin was substituted for the other tonics in ½ gramme doses, three times daily, and 3-grain capsules of quinine were given in the morning and at noon. At the end of two weeks all the nervous symptoms had disappeared. In the treatment of anemia he began with doses of the same quantity, but gradually increased them to double the amount. The results were equally satisfactory.

The Action of Thyroid Gland on Growth and Obesity.—BOURNEVILLE gives tables showing the action of thyroid gland on growth and obesity. In three cases of myxedematous idiots, aged from 14 to 30 years, the striking points were a loss of weight and an increase of waist measurement—that is, of growth. It was then tried in three cases of obesity in idiots (two macrocephalic, aged 11 and 28, and one epileptic, aged 11.) Their growth under treatment was proportionately more in four, five and six months, than the average growth of eighteen untreated imbeciles or epileptics during their tenth, eleventh and twelfth year, which were taken as more approaching normal children to control these experiments. This growth is still more apparent when compared with that before the thyroid treatment, when it was absent or retarded. As regards obesity, two of the idiots lost weight rapidly during treatment, while the third gained during treatment and lost weight rapidly afterwards. Otherwise, the rule was that: (1) There was a rapid loss of weight during treatment. (2) After a certain time the gland lost its effect and the weight remained stationary. (3) Generally, shortly after the treatment ceased, the weight rose again. Hence the necessity of breaks in the treatment. In the epileptic case the number of fits increased while the gland was being given. These results agree with those published by Hertoghe regarding the influence of thyroid gland on children whose growth has been retarded by causes other than myxedema (rickets, albuminuria, debility.)—*British Medical Journal*, March 21, 1896.

DR. JEVZYKOWSKI reports, in the *Noviny Lekarski*, ten cases of corpulence which he treated with dried thyreoidin, manufactured by Merck, with excellent results. This preparation was given in doses of 5 to 8 grains *per diem*, 10 grains of it being the equivalent of a thyroid gland from a medium sized calf. It did not give rise to any unpleasant by-effects such as have been noticed by some observers. In one case, however, that of a patient with fatty degeneration of the heart, suffering from occasional attacks of an anginal character, after some 300 5-grain doses had been taken, which had reduced the weight about 25 pounds, a considerable amount of dilatation of the left auricle was diagnosed, and the heart's action was weakened; this state of things lasted for about a fortnight, but afterwards the patient completely recovered and lost all tendency to anginal attacks. Speaking generally, Dr. Jevzykowski found that a very considerable decrease of weight was produced by the treatment, at all events where the patients were willing to give up their previous habits of over-eating and over-drinking. In one case more than 40 pounds were lost in two months, and, in another, 30 pounds in three months. Dr. Jevzykowski also tried the dried thyroeidin in a case of inveterate icthyosis, the skin regaining its ordinary character after five weeks' treatment. When thyreoidin was left off, however, the disease began to reappear; another course of the remedy in increased doses again improved it, and when the patient was last seen there were no signs of any recurrence.—*Lancet*, April 4, 1896.

MEDICINE AND PATHOLOGY.

By Albert Abrams, M.D., Professor of Pathology, Cooper Medical College, San Francisco.

Tuberculous Affections of the Heart.—Leyden, in the *Société de Médicine Berlinoise*, refers to the rarity of such affections. At the present day one can recognize during life a tuberculous pericarditis, and can cure it. In 1850 Rokitansky demonstrated the presence of tubercles in the myocardium. Upon the endocardium the presence of tubercles has been rarely observed. Its existence is dependent on a valvular endocarditis of a tuberculous nature. In 1,500 autopsies on phthisical subjects, Fenwick has found endocarditis in 43 cases; 13 of these cases which were acute developed in the course of tuberculosis. Leyden in his observations, maintains that the majority of cases of acute endocarditis are of an infectious nature, and caused directly by the action of the pathogenic organisms or their toxines. In 1886 Heller demonstrated for the first time the presence of the bacillus tuberculosis upon the cardiac valves. In three of his cases of endocarditis Leyden found the bacilli inclosed in cells which were evidently transported.—*Semaine Médicale*, December 4, 1895.

Demonstration of Tubercle Bacilli in the Sputum.—Prof. v. Rindfleisch (*Deutsch. med. Woch.*) suggests the following method: As is known the tubercle bacilli are conspicuously prominent in the pus of lung cavities, which is mixed with the bronchial secretion. The latter is made up of mucous balls into which the tubercle bacilli cannot enter. These facts warrant the assumption that if tubercle bacilli are present in the sputum, they can most easily be demonstrated in the fluid between the mucous balls. A camel's hair pencil is moistened in water and moved about in all directions in the sputum to be examined. When removed the brush will appear to have nothing attached to it; if, however, it is rubbed over an object, or cover glass, in the thin layer may be demonstrated very many tubercle bacilli. A new brush is naturally employed for each examination.—*Therapeutische Monatshefte*. January, 1896.

Graves's Disease—Edema of the Eyelids.—Dr. J. Arthur Booth presented before the New York Neurological Society, a case of Graves's disease, with the presence of a rather rare symptom—edema of the eyelids. On inspection the diagnosis of Graves's disease had been made, but the examination had revealed no exophthalmus. There was, however, slight enlargement of the thyroid and a rapid pulse. The patient, a girl, aged seventeen years, was very much frightened when quite young. She had some convulsions following this incident. About the time of her first menstruation edema of the eyelids first appeared. She now complained of palpitation of the heart, profuse sweating, headache, and general weakness. This edema, the speaker said, was not a true edema, as it did not "pit" on pressure. The movements of the lids were harmonious. On palpation, swelling and diffused hardness of the thyroid could be made out. When seen about one month later, *i. e.*, December 2d, there was apparently a slight prominence of one eyeball. Four examinations of the urine had been made, but nothing abnormal discovered.—*Medical News*, January 4, 1896.

The Value of Gastro-Diaphany.—MEINERT, by central methods employed ou 11 different patients, at his clinic, refers to the misleading information secured by the use of this method. The diaphanoscope will give varying pictures in different positions of the lamp. This instrument may aid in the detection of tumors in the neighborhood of the spleen, as well as in the topographical determination of palpable tumors of the stomach and parts in the neighborhood, but any attempt to determine the position, size and shape of the stomach is very unsuccessful.—*Centralbl. f. innere Med.*

Acromegaly.—DR. WORCESTER reports an interesting case of this affection, with autopsy, which is of value as the petuitary body was much enlarged; it weighed 58 grammes (89½ grs.), and measured 4.6 centimeters in its longest diameter. Microscopical examination proved it to be a sarcoma with psammomotous degeneration. Autopsies on cases of acromegaly have not been very numerous, but enough seems to have been reported to refute the hypothesis advocated in various quarters that the enlargment of the hyphophysis in acromegaly is, like the other hypertrophies, merely a symptom of the disease. He then proceeds to cite authorities in support of his position. He quotes Sternberg (*Zeitschr. f. klin. Med.*), who has collected reports of 19 cases, classified as follows: Hypertrophy, 3; hypertrophy with increase of connective tissue, 1; sarcoma, 3; adenoma, 2; softened adenoma, 1; tumor with little cavities lined with epithelium, 1; glioma, 1; tumors, character not specified, 3; vascular hypertrophy, 1; colloid degeneration, 1; sclerosis and atrophy, 1; necrosis with softening, 1. In addition to the foregoing he has found reports of the condition of the hypophysis in six cases: Petuitary body hypertrophied (Squance), (Dana): weight of hypophysis 4.5 grammes, apparently somewhat cystic. (Lathuray): petuitary body large and softened. (Bonardi): no tumor of hypophysis. (Tamburini): tumor size of a hen's egg; structure somewhat similar to that of the normal gland; little alveolar structure. (Sigurini): large, round-celled tumor. —*Boston Medical and Surgical Journal*, April 23, 1896.

The Treatment of Intestinal Affections Associated with Gastric Disease.—DR. BRUNO OPPLER notes the slight influence which recent investigations in the chemistry and pathology of digestion have made in the treatment of intestinal diseases. The writer believes that a large number of cases designated as enteric affections, are virtually diseases of the stomach. It is his custom, in every patient complaining of symptoms which might be attributed to the intestines, to examine the chemistry of gastric digestion. He selects two groups of symptoms for purposes of illustration, viz: constipation and diarrhea. Chronic constipation is one of the most frequent symptoms of patients seeking the advice of the physician. Many of these cases present the objective signs of an affection of the stomach, and it is to this class of cases that he directs attention. In such cases, the usual methods of intestinal examination prove negative. Not so, examination of the stomach. The latter is usually enlarged and dislocated downward; there is motor insufficiency and an increased production of hydrochloric acid. As a result of the long continued affection of the stomach, the obstipation may be treated. In such cases, the conventional treatment for constipation is without benefit. Treatment directed toward the atonia-ventriculi is followed by almost immediate good results. The HCl production is combated by magnesia, bismuth, and calcium carbonate in different combinations. In diet, great weight must be laid on restricting liquid nourishment. The fluid ingested should never exceed one liter and a half a day. Food should be ingested in small. portions only, every 2 or 3 hours, In addition to this treatment, hydriatic and electric procedures may be tried. There is another symptom indicative of an affection of the stomach, and that is, diarrhea. An examination of the stomach contents in these cases, after an experimental meal, shows the absence of hydrochloric acid, pepsin, and rennet ferment; the stomach is in a condition of apepsia just the same as occurs in atrophy of its mucous membrane. The food is completely undigested, and often mixed with mucus; fermentation and the development of organic acids do not occur, owing to the increased motor function of the stomach and intestines. A large number of such patients have an imperfect dental apparatus, which inadequately performs the important function of mastication. The treatment of these cases must be based on the usual methods.—*Therapeutic Monatshefte*, March, 1896.

The Infectiousness of Milk from Tuberculous Cows.—It has been determined that from 77 to 80 per cent. of all cows are tuberculous, and that the bacilli of tuberculosis frequently pass into the milk, even in those instances where the tuberculosis is latent. Obermüller inoculated guinea pigs with milk obtained in open market, and demonstrated that 38 per cent. of all the inoculated animals became tuberculous, of which 30 per cent. rapidly died of general tuberculosis. These investigations emphasize the importance of only consuming milk which has been boiled.—*Der Kinder Arzt*, January, 1896.

Pretuberculous Albuminuria.—According to TEISSIER, pretuberculous albuminuria occurs in young subjects, but not in cases of veritable hereditary tuberculosis. It is a precursory stage, somewhat related to congenital mitral stenosis so frequently encountered in the progeny of tuberculous parents, from which it differs, in particularly affecting male children, whereas the heart lesion is more frequent in girls. Its origin is often inexplicable, but it is due most probably to the congestive action of the tuberculous virus upon the kidneys. Teissier attributes the affection to an impregnation of the organism with tuberculin, which antedates bacillary invasion. The albuminuria is intermittent. The pale urine is usually of a high specific gravity, and very slightly acid, and even neutral in reaction. Pretuberculous albuminuria is characterized by the absence of casts or other morphological elements. When tuberculous invasion of the lungs becomes manifest, the albuminuria often disappears, so that the disappearance of this symptom without improvement in the general health, indicates the advent of phthisis.—*Semaine Médicale*, January 8, 1896.

An Autopsical Examination of 100 Cases of Diseases of the Heart.—JACKSON has studied these cases with a view of determining the etiological factors in the causation of various disturbances of the heart, and especially the *rôle* played by lesions of the valves in patients presenting the clinical phenomena of "cardiac cases." From the pathological data of the writer, the lesson may be drawn, that when by physical examination an enlargement of the heart can be diagnosed, we have already a certain dilatation of its cavities, and are to watch carefully to determine the time when the compensatory hypertrophy is beginning to fail, and we must with the aid of various things, step in to assist nature to fight against the obstacles which are already beginning to overpower the heart. A review of the clinical histories of the cases of valvular disease is satisfactory as to the correspondence of the clinical diagnosis with the results of the *post-mortem* diagnosis. In 5 cases, the records state, that the heart was normal where there was after death a "thickening" of the mitral valve. Apparently the lesion which most frequently escaped observation was aortic disease, combined with insufficiency of the mitral valve; 4 of these cases are noted, and in one the aortic lesion is described as extreme stenosis. Three cases of mitral stenosis were not recognized, the only sign during life being a systolic murmur at the apex; this lesion is certainly the most difficult of diagnosis, and often exists without giving rise to a murmur. From the clinical records it is difficult to determine the relative accuracy of percussion in diagnosing the size of the heart. The important *rôle* played by diseases of the arteries in causing "heart disease" is seen, in that this was the cause of the trouble in some 60 per cent. of the cases of disease of the heart, independent of valvular lesion. It is to be further noted, that the presence of murmur is not of value in eliminating organic valvular disease.—*Boston Medical and Surgical Journal*, May 21, 1896.

MENTAL DISEASES AND MEDICAL JURISPRUDENCE.

By A. W. HOISHOLT, M.D., Assistant Physician, State Asylum for Insane,
Stockton, Cal.

Tabes and General Paralysis.—DR. H. HANNION reports a case of tabes in an individual 37 years old, who for 4 years had presented the clinical picture of this disease, when the symptoms of a typical general paralysis developed. The *post-mortem* examination demonstrated, besides a diffuse encephalitis, diffuse atrophy and sclerosis of the spinal cord. The posterior columns were affected throughout their course and in the lumbar portion of the cord the posterior roots showed some atrophy. The diagnosis made was, as in a similar case reported by Joffroy, in 1894, at the Congress of Clermond-Ferrand, the spinal form of general paralysis. The coëxistence of a tabes is excluded, as the degeneration of the posterior roots, even in an incipient case of tabes, is much more pronounced.—*Gaz. hebdom. de méd. et de Chir.—Centralblatt f. Innere Medicin.*

The Confessions of a Cocainist.—DR. J. W. SPRINGTHORPE reports a case of cocainism in a medical man of great intelligence, who became habituated to the use of cocaine when serving in the German army. After an interval of four years, during which he had not taken any cocaine, he witnessed the wonderful effect of the drug upon a colleague, and again yielded to the temptation to use it. Within a month from this time he was taking from 80 to 120 grains of cocaine daily. The largest single dose he took was 20 grains, which caused him to fall down suddenly, and to remain in a cataleptic condition for some hours. He describes the sensations of a cocainist as: First, an indescribable excitement, with the thought of doing something great; then, the hearing becomes greatly increased, and soon every sound seems to be an unpleasant remark about one's self; bugs and worms are felt, and even seen upon the person and clothing, and later, many frightful hallucinations, all of a persecutory nature, are present. The cocainist early loses all appetite for solid food, but likes sweets. Diarrhea is soon produced, and immediate evacuation often follows large injections of the medicine. The drug is a powerful stimulant to the muscular system; it increases the number of respiratory and cardiac contractions, the quantity of urine and of the perspiration; it stimulates the sexual appetite, and the pupils are dilated after each injection. Mental processes seem quickened, and the brain works without and even against the will. Hallucinations and illusions are early symptoms. The sense of right and wrong is not abolished, but the moral sense becomes blunted, and the person may in time become a scoundrel or a criminal. The cocaine habit is distinguished from others by the change of associations of the person, his neglected appearance, the dilated pupils, restlessness, hallucinations, illusions and expression of anguish.—*Australasian Medical Gazette—International Medical Magazine.*

Paralysis in the Region of the Nervus Peroneus in Dementia Paralytica. DR. MOELI has made five observations of peripheral paralysis in cases of general paresis, a symptom to which, so far, reference has seldom been made in medical literature. The variation in the electric irritability and the limitation of the paralysis in these cases could hardly have been explained by a disease of the anterior horns. In two of the cases a *post-mortem* examination was obtained, and it was found that the anterior horns were intact, which contradicts a recent statement made by Hoch that these organs are diseased in general paresis. Dr. Moeli's five cases had this in common that the symptom was present in a not very far advanced stage of the disease; the knee-jerk was absent in all. The absence of the knee phenomenon cannot well be ascribed to a disease of the quadriceps and nervus cruralis, which, moreover, were examined and found intact in one case. The symptom of Westphal must, therefore, in these five cases be considered a symptom of disease of the lumbar portion of the spinal cord. It is a well known fact that in tabes the peroneus is frequently the seat of paralysis, but the writer failed to find etiological factors pointing towards the development of a disease of the peroneus in these cases in which disease of the posterior columns of the cord was present. Dr. Moeli ascribes the paralysis to an over-exertion of the muscles innervated by this nerve. The elevation of the point of the foot is an important part of the muscular movements made in walking, and especially so when, on account of even slight irregularity in the coördination of the muscles, an unsteadiness in the walk is produced. This must lead to an increased activity of this group of muscles. The development of neuritic processes after repeated over-exertion has frequently been observed. Lesion of the lumbar portion of the spinal cord may well be thought to cause a disturbance of the muscular apparatus here involved, which was overtaxed by reason of the restlessness and constant walking about accompanying the psychic condition of the patients.—*Neurolog. Centralblatt—Centralblatt f. Innere Medicin.*

Uncontrollable Laughing and Crying in Cerebral Affections.—PROF. BECHTEREW has had opportunity to make a number of observations, which throw some light on the pathogenesis of the above symptoms. In all his cases there were lesions in the cerebral cortex or in the adjoining medullary substance. The motor centers were in all the cases affected, so that simultaneously there was present hemiplegia, aphasia, or monoplegia; the facialis being always involved. In most of the cases the affections were bilateral. In speaking of the physiology of the acts of laughing and crying, Prof. Bechterew says, that all the vasomotor phenomena and muscular movements concerned in the same proceed from the cerebral cortex. Still, the supposition of the existence of a mimic center in the cerebral cortex is not supported by clinical facts; however, it has been demonstrated to a certainty, and especially by Bechterew, that there is such a center in the thalami optici. It is from this center that all movements involved in the facial expression take their origin. If they really proceed from the cortex, they can only be accomplished by way of the fibers going to the optic thalamus. The fibers have partly a stimulating and partly an inhibitory function. The uncontrollable laugh produced by pathological processes, may, therefore, be produced either by over stimulation or by paralysis of the inhibition. Bechterew is of the opinion that the latter explanation is the correct one, especially in those cases in which the symptom is produced by organic lesions. In favor of this supposition may be mentioned, that usually this laugh results from an external impulse, even if the latter be ever so slight. Another fact, corroborating this idea, is that the lesion is usually bilateral. It would seem that in certain neuroses the cause of the development of this symptom may, in certain cases, be a stimulation of the center. With regard to the frequency of the symptom, it is said that it is not very uncommon, being especially observed in general paralysis, cerebral syphilis, cerebral tumors, and softenings. It has also been observed in neuroses; for instance, in hysteria.—*Arch. f. Psych. u. Nervenkrankheiten—Centralbl. f. innere Medicin.*

The Circulation of the Blood in the Brain During the Epileptic Attack. DR. A. TODORSKI has made a number of experiments on dogs in the laboratory of Prof. Bechterew, in which he measured, during the epileptic attack, the arterial and venous blood pressure, as well as the cerebro-spinal pressure, which latter was taken in the foramen vertebrale from behind and above the arch of the atlas. The spasms were produced either by stimulation of the cerebral cortex, by means of the faradic current, or by venous injection of essence of absinth. In cases in which the epileptiform spasms were produced by faradic stimulation of the cerebral cortex in dogs not under the influence of curare, an increase in the arterial pressure, taken in the internal carotid, or crural artery, set in some seconds after the stimulation, or at its commencement; at the same time there was an elevation of the venous pressure (taken in the internal jugular and the longitudinal sinus). The venous pressure remains increased as long as the faradic current is applied. During the period of tonic spasms, a similar increase in the arterial and venous blood pressure is observed, reaching its maximum at the beginning of the clonic contractions. The arterial pressure diminishes before the venous blood pressure shows any diminution. The venous pressure again becomes normal at the end of the comatose state. The same observations were made on curarized dogs, and after section of the vagus and sympathetic, thus showing that the increase in the venous blood pressure in the brain was not due to obstruction to the flow of blood into the chest and abdominal cavities by the excessive muscular contractions. The increase in the pressure of the cerebro-spinal fluid during faradic stimulation runs parallel with the arterial and venous pressure. This increase lasts, frequently, longer than that of the arterial and venous pressure. The author concludes, from these results, that the rush of blood to the brain, during the epileptic attack, produces an increased secretion of cerebral lymph. When the epileptiform spasms were produced by injection of essence of absinth, it was observed that the curve of increase of the cerebro-spinal pressure frequently showed an upward tendency immediately after the injection, while the arterial blood pressure fell. Whenever the increase in the cerebral pressure reached a

certain hight, the epileptic attack would set in, while the cerebrospinal pressure would rise still higher. Otherwise, the results were the same as when stimulation was made with the faradic current.—*Medicinskoje Obosrenje, Centralblatt f. Innere Medicin.*

An Action for Malpractice Against a Physician a Waiver of the Benefits of the Statute Privileging Confidential Communications.—MR. LORENZO D. BULETTE, of the Philadelphia Bar, in speaking of the statutes which prevent a physician from disclosing the information necessary for medical treatment imparted to him by a patient, says that this privilege is for the benefit of the patient only, and not the physician, but may be waived by the former, either in express terms or impliedly, by a course of conduct which the Courts, in construing these statutes of privilege, have declared to amount to a waiver. It has accordingly been decided that, in bringing an action for malpractice against his physician, the patient forfeits his right to have the secrets of the sick-room preserved inviolate in such judicial proceeding. In a recent suit for malpractice, in which a patient accused his physician of failing to properly treat and set a dislocated hip, the evidence showed that the defendant was called in on the day of the injury, and concluded, after a slight examination, that the injury was a mere bruise; prescribed some liniment, went away, and did not repeat his call until requested to do so ten days afterwards. At this time, although the surgeon's attention was called to the presence of well-marked symptoms of dislocation, yet he made but a slight examination, and failed to discover the nature of the injury. Fourteen days after the injury he did discover the dislocation, and made an unsuccessful attempt to reduce it. Evidence was also introduced to prove that after the physician had unsuccessfully treated the patient for two months, he recommended the latter to go to a certain city, where surgeons were better prepared and equipped to treat such cases. The defendant went with the plaintiff to this city, where he consulted a certain physician, who, with the defendant, made a careful examination, and advised the latter as to the proper course to be pursued. In his defense, the defendant offered to prove by himself and the physician consulted what occurred at this examination, and the condition and nature of the patient's injury at this time. To this the plaintiff objected, on the ground that these were confidential communications, and the evidence was rejected, his counsel seeking to sustain the ruling on this ground, and also on the ground that the evidence offered was as to matters occurring entirely subsequent to the defendant's treatment of which complaint is made, and disconnected therewith. A verdict was rendered for the plaintiff for $1,500; but the Supreme Court reversed a judgment rendered therein, and instructed the trial Court to sustain the defendant's motion for a new trial.—*International Medical Magazine.*

FORMULÆ.

By H. E. SANDERSON, Ph.B., M.D., Assistant Physician State Asylum for Insane, Stockton, Cal.

To Allay the Craving for Alcohol:

Tinct. capsici
Tinct. nucis vomicæ
Acid nitro-muriatic dilut. āā ʒj
Infusion. gentian.. .*q.s. ad.* ℥xii

S.—Two tablespoonfuls every two hours.

Measles.—DR. Wells recommends for the conjunctivitis, bichloride solution 1:12000 dropped into the eyes twice a day, followed by washings with boric acid solution; and for the cough, five drop doses of fld. ext. eucalyptus.—*Philadelphia Polyclinic.*

Eczema.—The following has been found good, after having softened and removed the crusts:

Ungt. picis.
Ungt. diachylon.
Ungt. zinci oxidi, equal parts.

—*Pediatrics.*

Rachitis.—GUINON advises:

Phosphorus	1/7	grain
Saccharin	77	grains
Essence of lemon	2	minims
Codliver oil	3½	ounces

S.—Teaspoonful three times a day.

—*Medical Record.*

Neuralgia.—S. SOLIS COHEN prescribes for neuralgia, and many vague pains externally:

Menthol
Chloral
Camphor—equal parts.

—*Philadelphia Polyclinic.*

Warts:

Flowers of sulphur	150	grains
Glycerine	375	minims
Pure acetic acid	75	minims

S.—Apply twice a day.

—*Lyon Médicale.*

PUBLIC HEALTH.

By W. R. CLUNESS, M.A., M.D., San Francisco, Cal.

Mortality for April, 1896.—The deaths registered in 57 town districts of the State, during the month of April, in a population of 622,104, correspond to an annual rate of 18.84 a thousand, the total mortality having been 982. 45 deaths were due to zymotic diseases, giving an annual rate of .864 a thousand. Of these, 5 were due to diphtheria, 3 to cholera infantum, 17 to typhoid fever, 1 to diarrhea and dysentery, 5 to cerebro-spinal fever, 2 to whooping cough, 3 to croup, 4 to intermittent and remittent fevers, 1 to scarlet fever, 4 to measles, and 0 to small-pox. 292 deaths resulted from diseases of the respiratory organs, giving an annual rate of 5.62 a thousand. Of these, 183 were due to consumption, 75 to pneumonia, 27 to bronchitis, and 7 to pulmonary congestion; the rate being, for consumption and pneumonia, 3.48 and 1.44, respectively. 103 deaths resulted from diseases of the heart, 6 from alcoholism, 4 from erysipelas, 45 from cancer, and 427 from causes not given. The average annual death rate from all causes occurring in the ten largest cities and towns in the State, and representing a population of 586,000, was 16.40. The highest rate for the month occurring in cities having a population of 10,000 or more inhabitants, was reported from Vallejo, the lowest from Berkeley.

METEOROLOGY.

Summary for April—*Temperature.*—The normal temperature of the State for April is 57.7°; the average for April, 1896, was 52.8°, a departure from the normal of -4.9°. The highest monthly mean was 73.8°, at Volcano Springs; the lowest, 27°, at Bodie. The maximum temperature was 100° at Volcano Springs, on the 29th. The minimum, zero, at Bodie, on the 1st. The absolute range for the State was 100°. The greatest monthly range was 60°, at Tulare; the least, 19°, at Point Lobos.

Rainfall.—The normal precipitation for the State for April is 2.36 inches; the average for April, 1896, was 4.40 inches, a departure from the normal of +2.04 inches. The greatest monthly precipitation was 18.45 inches, at Bowman Dam; the least, nothing, at numerous places throughout the State.

Wind.—The prevailing direction of wind was W. SW.

Unusual Features.—The unusual meterological phenomena of the month was the great departure from normal temperature and the continued cold, with heavy and killing frost during the greater part of the month; and, also, the excessive precipitation, as compared with the normal amount usually measured during this month.—JAMES A. BARWICK, Director California Weather Service.

California—Tabular Statement for April, 1896.

STATIONS.	TEMPERATURE.						RAINFALL.		Mean Relative Humidity	WEATHER.			WIND.	FURNISHED BY—
	Mean	Highest	Lowest	Mean Highest	Mean Lowest	Mean Daily Range	No of Days Rain Fell	Total Rainfall		No. of Clear Days	No. of Fair Days	No. of Cloudy Days	Prevailing Direction.	
Auburn ....Cal.	52.0	72	38	----	----	----	----	7.66	----	----	----	----	N.E.	Southern Pacific Company.
Berkeley......... "	52 0	66	36	59	44	15	9	6.72	86	14	5	11	S.E.	Obs. University of California.
Colfax........... "	47.0	72	32	----	----	----	----	16.15	----	----	----	----	S.E.	Southern Pacific Company.
Coronado........ "	----	----	----	----	----	----	----	----	----	----	----	----	----	Hotel del Coronado.
Eureka.......... "	48.0	62	35	55	41	14	23	11 13	82	1	18	11	S.E.	Weather Bureau Dept. Agr.
Fresno.......... "	55.0	76	34	66	43	23	7	2.82	61	15	8	7	N.W.	" " "
Keeler .... "	59.0	76	40	----	----	----	----	T	----	----	----	----	S.W.	" " "
Los Angeles.... "	56.0	81	38	67	46	21	4	0.19	67	11	16	3	W.	" " "
Monterey .... "	54.0	68	40	----	----	----	----	2.17	----	----	----	----	S.	Southern Pacific Company.
Napa........... . "	53.0	76	32	64	41	23	12	6.28	82	11	11	8	S.W.	Station Napa Insane Asylum.
Oakland......... "	54.0	70	39	62	45	17	14	6.88	75	14	8	8	N.W.	Chabot Observatory.
Paso Robles.... "	49.0	69	28	60	39	21	7	1.25	62	14	4	12	W.	Agr. Experimental Station.
Red Bluff....... "	52.0	74	34	61	43	18	11	3 67	65	9	8	13	S.E.	Weather Bureau Dept. Agr.
Sacramento. ... "	53.0	72	36	62	45	17	10	5 34	73	12	7	11	S.W.	" " "
San Bernardino "	56 0	82	30	72	41	31	4	0.37	----	19	8	3	W.	A. K. Johnson, M. D
San Diego....... "	56.0	74	42	64	49	15	4	0.25	70	26	2	2	N.W.	Weather Bureau Dept. Agr.
San Francisco.. "	52.0	66	41	56	47	9	15	5.16	76	12	3	15	W.	" " "
Santa Barbara.. "	55.0	76	36	65	46	19	4	1.78	65	24	3	3	W.	Hugh D. Vail.
Santa Cruz...... "	53.0	75	31	66	40	26	10	3.07	----	13	9	8	W.	W. R. Springer.
Yuma...........A. T.	66.0	91	41	81	50	31	1	T	36	25	5	0	W.	Weather Bureau Dept. Agr.

NOTE—Mean humidity at Paso Robles is of the 2 P. M. observation. Blank (----) indicates data missing.

Occidental Medical Times.

COMMUNICATIONS are invited from all parts of the world. When necessary to elucidate the text, illustrations will be furnished without cost to the author.

SACRAMENTO: JUNE, 1896.

THE COMMENCEMENTS—MEDICAL DEPARTMENT UNIVERSITY OF CALIFORNIA.

The commencement exercises of the Medical Department of the University of California were held at the Baldwin Theater, on Thursday, May 21st, at 2 P. M. After prayer by BISHOP NICHOLS, the valedictory address on behalf the Faculty was delivered by DR. G. F. SHIELS, Associate Professor of Principles and Practice of Surgery. The degrees were conferred by the President of the University, MARTIN KELLOGG. PROF. R. BEVERLEY COLE, President of the Faculty, administering the hippocratic oath to the graduates.

The following are the names of the graduates: Clifford Emmet Allen, Helen Orastella Anderson, Cecil Miller Armistead, Henry Martin Beck, Ph. G.; Sanford Blum, B.A.; Mary Elizabeth Botsford, George Anthony Broughton, William Parker Burnham, Howard McDougall Cameron, William D'Arcy Chace, Leonard Hayes Coe, Thomas Francis Cox, Attilio Henry Giannini, B.A.; Joseph Thomas Harrigan, Ichitaro Katsuki, James Frederic Kearney, Wilfred Harvey Kellogg, Ph. G.; Arthur Stanley Lee, Thomas Davis Maher, B.Sc.; Clarence Lafayette Maloon, B.Sc.; Charles Lewis Morgan, B.A., Ph. G.; Howard Morrow, James Daniel Murphy, Brayton Muscott, Charles Dominic McGettigan, B.A.; Alfred McLaughlin, Alfred Newman, B.A.; Mary Louisa Noble, Louise Augusta Oldenbourg, Robert Harris Orr, John Henry O'Brien, John Thomas O'Brien, William Henry Ingram O'Malley, George Louis Painter, Ph. G.; Wallace Ernest Parkman, Victor Eugene Putnam, Joseph Rochex, Marshall Bragg Ryer, Florence Scott, John Thomas Stafford, Arthur Alonzo Stern, Ph. G.; Mary Jane Stewart, Mack Voorhees Stone, William Miller Stover, Eleanor May Stow, Lewis Sanborn Thorpe, Henry Caustin Trask, Ph. G.; Alberto Trevino, Newton Booth Waller.

The total number of students in attendance during the past session was ooo, the number of matriculates being ooo.

THE COMPULSORY REGISTRATION OF BIRTHS BY PHYSICIANS, UNDER PENALTY.

DR. L. F. GARRIGUES, of San Francisco, was arrested recently by order of the Health Officer for failing to report a birth. No contest was made, and a nominal fine of five dollars was imposed. The Health Officer maintains that the birth statistics compare very unfavorably with those of other large cities, and that the cause is failure on the part of physicians to report the births occurring in their practice.

It may be conceded that many births are not reported, and that the Health Officer is justified in taking all steps in his power to render his reports as accurate as possible; but the law imposing on physicians the duty of reporting births is clearly unjust. It is going out of the way to select for this duty a third party, who has no more interest in the registration than any other good citizen. The only parties directly interested in recording a birth are the parents and the health department, and naturally the duty should be imposed on the parents, as is done in most civilized communities outside the United States.

To single out a particular set of citizens for gratuitous public work, and to fix as penalties fines or imprisonment in case of failure to carry out the law, is certainly class legislation, and as such contrary to the fundamental principles of our laws. Even as it is, physicians do more gratuitous work for the welfare of a community than any other class of citizens, and are ever ready to offer their services where they can justly further the public weal. Were they merely asked to aid the health department by voluntary reports, the task would no doubt be willingly assumed until such time as a proper and just method of obtaining the statistics could be devised, but it is particularly galling to be held criminally responsible for the carrying out of an unjust law which imposes a gratuitous and unusual task.

Several reasons have been advanced why physicians should accept the law as fair. It is said that the work involved is trivial, that physicians are accustomed to keep records of their cases, that parents are oftentimes too ignorant to be aware of the law, and that in return for the license to practice, physicians ought to be willing to do at least this work. Such arguments are beside the point, for they avoid the principle involved. The principle is one of justice, and did it concern the legal profession as it does the medical, it would be obnoxious enough to raise vigorous protests. It is true that ordinarily the amount of labor expended in making a report is small, requiring nothing further than a little clerical work, an occasional trip to the health office to obtain a supply of certificates, and the procuring of a few postage stamps each month; but at times, perhaps through some oversight, or from incorrect data, a physician is put to considerable trouble to procure a correct certificate. Again, knowledge of a birth is often in the nature of a professional secret, and would not be divulged by any physician.

As to the point that physicians are better fitted than parents for making returns, the law states that in the absence of a physician or midwife, the parents must make the report. Why not the parents in all cases? It is just among the ignorant classes that physicians are least employed, and if the ignorant, and those who are unable to employ physicians, may be compelled to report births, certainly there is no good reason why the better classes should not be called upon to perform the same duty.

Regarding the question of a return for the license to practice, the proposition is absurd, for the State does nothing to protect the possessor of a license, and he is practically as well off, before the law, without one. But, after all, the patient profession does not complain of the duty imposed by this law, for it is simply one, added to the many gratuitous services entailed by custom. It does, however, complain of the liability to prosecution as a criminal for failure to carry out the provisions of an unjust and discriminating law.

NOTES.

California Northern District Medical Society.

The following have been appointed as the Committee of Arrangements for the annual meeting of the California Northern District Medical Society, to be held in Marysville, October 13, 1896: David Powell, Chairman; G. W. Stratton, J. H. Barr, E. E. Stone, Marysville, and A. E. Kosby, Yuba City.

The Reduction in Fees of Medical Examiners for Life Insurance.

At a regular meeting of the Placer County Medical Society, held April 7, 1896, the resolutions passed by the Sacramento Society for Medical Improvement in regard to the lowering of fees by the Equitable and the New York Life Insurance Companies, were unanimously adopted. The members present pledged themselves to, in every way, assist their medical brethren throughout the State in the fight against these insurance companies.

Alumni Association—Medical Department, University of California—Annual Meeting.

The annual meeting of the Alumni Association of the Medical Department of the University of California, was held at the rooms of the Dental College, Market and Taylor streets, Friday, April 10, 1896, at 8 P. M. Minutes of the previous meeting were read and on motion adopted. The following were nominated and elected officers for the ensuing year: Dr. J. M. Williamson, President; Dr. Daniel E. F. Easton, Vice-President; Dr. L. M. F. Wanzer, Secretary; Dr. F. E. McCullough, Treasurer; Dr. Henry Kugeler, Dr. Harry A. L. Ryfkogel, Dr. Chas. S. Maguire, Executive Committee. The Committee on Revision of Constitution and By-laws was granted further time. The question of the annual banquet was discussed. Drs. D'Ancona, McMurdo, and Barbat were appointed a Committee of Arrangements, with full power to act. Dr. Ryfkogel read a paper on Formaline as an ideal preservative and fixing agent for specimens of organic life. He held that this preservative affected animal pigment but slightly and caused no shrinkage. He finds that solutions of 1 per cent. strength, *i. e.*, one volume of Formaline to forty of water, preserve gross specimens of tissue indefinitely, and so thoroughly that microscopic sections may be prepared therefrom at any time. Solutions of even less strength may be used, but with less satisfactory results as regards preservation of color and minute detail. When the object to be preserved has many delicate colors that must be shown, a stronger solution, *e. g.*, 4 to 8 per cent. had better be employed. Formaline gives beautiful results in the preservation of the central nervous system, showing very distinctly the white and gray matter. For this purpose, however, it has two objections: first, it causes a certain amount of swelling, and, second, the gray matter becomes very brittle. These may both be remedied by working up the 1 per cent. solution in 50 per cent. alcohol. The objection to Formaline is the irritating qualities of its vapor when inhaled. This, however, is not troublesome in the solutions ordinarily employed. Several specimens were shown to illustrate the advantages of Formaline. By invitation, a universal splint, adjustable, was exhibited by Mr. R. Hoppe.

Second Pan American Medical Congress.

The following preliminary announcement has been issued by the International Executive Committee for the United States. The names of the committee are: William Pepper, *ex officio* President; A. M. Owen, A. Vander Veer, and Chas. A. L. Reed, *ex officio* Secretary.

The Committee on Organization of the Second Pan-American Medical Congress has elected Dr. Manuel Carmona y Valle, President; Dr. Rafael Lavista, Vice-President, and Dr. Eduardo Liceaga, Secretary, and has announced November 16th, 17th, 18th, 19th, 1896, as the date of the meeting, to be held in the City of Mexico. The most cordial invitation is extended to the medical profession of the United States to attend and participate in the meeting. Titles of papers to be read should be sent at the earliest practicable date to Dr. Eduardo Liceaga, Calle de San Andres num. 4, Ciudad de Mexico D. F., Republica Mexicana. The date selected is in the midst of the delightful midwinter season, when the climate of Mexico is the most attractive to the northern visitor. The occasion should stimulate the medical profession of the United States to a most cordial reciprocation of the generous patronage accorded the Washington meeting of the Congress by our Mexican confreres. It should be remembered that the United States is the largest, and in many regards the most important of the American countries, and that as a consequence more is expected of it than of any other Occidental Nation. In no particular is this more true than in the maintenance of position in the realm of scientific medicine on the Western Hemisphere. It is, therefore, simply essential that in this Congress—the most important of all Medical Congresses, in its exclusive, yet broad, American significance—the best thought and the best work of the American profession shall be conspicuous in the proceedings. The zeal and enthusiasm of the Mexican profession, and the active interest of the Mexican Government are co-operating to make the second Pan-American Medical Congress attractive, important and memorable. Those who contemplate attending should send their names and addresses at as early a date as possible to Dr. Charles A. L. Reed, St. Leger Place, Cincinnati, that the committee in Mexico may be advised of the probable attendance.

SACRAMENTO SOCIETY FOR MEDICAL IMPROVEMENT.

Regular Meeting, April 28, 1896.

The President, F. B. SUTLIFF, M.D., in the Chair.

New Member.—J. H. O'CONNOR, M.D., was duly elected a member of the Society.

Chancre.—DR. GEORGE W. OGDEN read a paper with this title. He said the subject was a very important one, as an error in diagnosis not only reflected upon the physician, but inflicted an irreparable injury on the patient. It was well known that syphilitic infection occurred in places other than the sexual organs, and that it was received by other means than natural intercourse. It was, therefore, at times exceedingly difficult to secure a history, or the date of possible infection, from which to calculate the appearance of the initial lesion. To fix the period of incubation was the most important factor in the diagnosis, distinguishing, as it did, a local from a constitutional affection. The appearance of a suspicious sore upon the genitals, or elsewhere, occurring after an interval of two or three weeks from a probable exposure, usually indicated a true chancre, with subsequent constitutional symptoms. The virus is sometimes deposited in a wound, or abrasion, occurring at the time of coition. In such a case it was impossible to say when the simple wound had developed into the specific lesion. Induration of the sore, and of the adjacent glands, was an important diagnostic feature, and was rarely wanting. Induration of the sore itself was not permanent, and it had sometimes passed away when the surgeon saw it. The speaker then contrasted in detail the characteristics, symptoms and physical appearances of the two types of sores. The conclusion to be reached in all cases of a doubtful character was to defer constitutional treatment, and keep the patient under careful observation until the period for the occurrence of secondary symptoms had passed.

Dr. F. Gundrum: I wish to refer to one portion of the paper only, and that is the treatment of patients who come to us with a sore on the penis. This matter of syphilis is a very serious affair to the man who contracts it, and it becomes still more serious if time is not taken to make a correct diagnosis. There are some cases of chancre that can be diagnosed readily, but I believe it is a good plan to wait until secondary manifestations break out. There is no time lost, the patient is not endangered, and then you know positively what you have to deal with. I have a man under my observation now who has been treated by having mercury poured into him for two and a half years. I cannot find any manifestations of syphilis. He said the physician who treated him said he had a soft chancre, and put him on anti-syphilitic treatment. That too often becomes the case when the physician undertakes to treat a case as syphilis, just because the patient has a sore.

Dr. T. A. Snider: I never put a patient upon constitutional treatment until secondary manifestations make their appearance. I treat the sore to heal it up, but wait for secondary symptoms before putting the patient on constitutional treatment. I had a patient, some two years ago, whom I treated for gonorrhea, when a chancre appeared. I told him he had a chancre, but that he had better wait a certain time before I put him on constitutional treatment. At the end of thirty days he broke out all over the body. I then put him on constitutional treatment, and had him under observation for two years. He got entirely well. It is my rule not to put a man on mercury until eruptions appear.

Dr. H. W. Strader: There is one rule I follow in treating cases of syphilis, where I am not positive as to the diagnosis at first—that is, putting the patient on iron, with proper diet. When the manifestations of constitutional syphilis appear, I give iodide of potassium.

Dr. W. H. Baldwin: Occasionally cases of hunterian chancre have come under my observation, which, if left alone, will get well, and there will be no constitutional symptoms following. As has been remarked, we overload our patients with iodides, without keeping in mind the general health and the individual idiosyncracy. At present I have a case on hand which, in spite of very large doses of iodides, refused to come under control until I had used about a grain and a half of bichloride of mercury, hypodermically. Occasionally had to stop the remedy on account of stomach derangements.

Dr. T. W. Huntington: It seems to me the time of incubation, from the exposure to the initial sore, where it can be determined accurately, is the diagnostic point. Where I am suspicious the sore is of true specific origin—where I am suspicious I have a hunterian chancre, I use every effort to determine the period of incubation. I should not like to lose much time in waiting, and I believe that the average physician, if unfortunate enough to become infected with syphilis, would not want to take any chances in waiting for secondary symptoms. I should prefer to saturate myself with anti-syphilitic remedies rather than to wait until it was fully demonstrated that I had syphilis. During the earlier stages of infection I believe mercury will accomplish all that any drug can do. It is also a fact that change of climate, in cases of syphilis, is beneficial. I think it is a mistake to tell your patient that you are in doubt, and that you are waiting. I would put him on some treatment, as suggested by Dr. Strader, and give him to understand he was under treatment for syphilis. It is a great mistake to impress upon the mind of a patient that you are waiting.

Dr. J. H. Parkinson: I think the position taken by the author is, in the main, correct. In a case of primary sore in which there is no doubt, I should certainly begin specific treatment at once; but where there is much doubt, I should certainly prefer waiting until secondary symptoms resulted before adopting active anti-syphilitic treatment. I prefer to use mercureal preparations the first year and iodides in the later symptoms.

Dr. J. R. Lainé: It is a safe rule to treat syphilis when it is active, and to let it alone when it is not. When a chancre is healed, I give blue mass 3 times a week. I try to heal the sore as quickly as possible.

Dr. L. A. Harcourt: Physicians are too indefinite in their expressions. I think the great bulk of testimony is in favor of the expectant plan. If you can see the initial lesion early, treat it; but if you see it late, wait. Whatever the sore may be, treat symptoms. It is generally acknowledged that when the virus finds its way into the system, it is never eliminated, and may be traced 10, 20, or 40 years after. A great deal depends on the general health and environment.

Dr. W. E. Briggs: In my practice I never saw an initial lesion of syphilis, but I have seen a great many secondary and tertiary lesions. It has often occurred to me, and I think it is a fact, that physicians give their patients so little instruction regarding the probable course of the disease, and too often treat them without even telling them they have syphilis. It seems to me that this is a mistake, as the patient, sooner or later, is likely to find out that he has had syphilis, and from the fact of your not having told him so, he will very likely arrive at the conclusion that you did not know what was the matter. Another thing that has occurred to me frequently is, that physicians, when treating secondary lesions, tell the patient he is cured, and often the patient concludes that he is cured forever, and that he can marry and have healthy children. Recently a case came under my observation, in which the patient believed he was never to have any more syphilis, and he got married and raised a family. He brought a child to my office suffering from interotitial keratitis, the trouble being due to inherited syphilis. He did not know that the child inherited the disease until that time. This is a frequent occurrence. It seems to me that to tell a patient he is cured of syphilis is a mistake, because I believe when a man once contracts the disease, it is uncertain whether we can thoroughly eradicate it from his system, and he ought to be instructed that in case he should marry and have children, he is taking serious chances.

SAN FRANCISCO COUNTY MEDICAL SOCIETY.

Regular Meeting, April 14, 1896.

The President, Wm. Fitch Cheney, M.D., in the Chair.

The Use of Pessaries for the Treatment of Backward Displacements of the Uterus.—Dr. C. Cushing, in a paper upon this subject, said: Although this is an old and much-worn subject in these days of surgical work, it seems well to go back and discuss some of the old methods of treatment. The text-books on the subject give various and indifferent discussions as to the treatment of retro-displacements, hence it seems best to give some practical results of personal experience. First, as to the normal position of the uterus: Great efforts have been made to ascertain this, but it is almost impossible to do so, and to agree about it, on account of the differences in measurements of the pelvis, vagina, etc. There are only about one in ten thousand women who are just alike in uterus, pelvis-shape and dimensions, length, depth and shape of vagina, etc. Whether the bladder be full or empty changes the position of the uterus when examined. The uterus is near the center of the pelvis in all directions, and is generally ante-verted. I do not believe in ante-version as a disease, in spite of the teachings of Dr. T. G. Thomas, and other able men. Another point is, whether backward displacement necessarily produced symptoms indicating disease. Physicians of slight experience must have seen cases in which there were no symptoms of disease manifest, though the fundus was well back against the sacrum. The general rule, however, is that long-continued displacements will produce disease. I am more and more convinced that it is disease of the uterus, along with the displacement, that produces the troublesome symptoms. I have treated many such cases, curing the uterine disease, and the patient seemed well, while the displacement still remained. *Post-mortem* examinations showed that 16 per cent. of female cadavers had retro-displacements. A French writer found 15 per cent. of retro-flexions in the autopsies made upon individuals. The predisposing cause is anything that produces a relaxed state of the tissues and body, especially of the pelvic tissues. The uterus is a very movable organ. A broad and wide pelvis gives a weak and relaxed state of all the contained tissues. The exciting causes are many. Aside from direct injury, anything causing pressure upon the abdomen, as corsets, etc., the after effects of child-birth causing relaxation of the pelvic tissues. If the patient lies on her back too long, or gets on her feet too soon, or wears too tight a bandage, she may have retroversion as a result. It seems hardly probable, as is often said, that adhesions cause retroversions or retroflexions. The symptoms are not so much the result of backward displacements of the uterus, as of disease in and around that organ. The symptoms are the common ones of any uterine disease—backache, sterility leucorrhea, etc. A diagnosis is usually easily made, especially by bimanual examination. If, however, there is a mass of organized lymph in Douglass' *cul-de-sac*, or a prolapsed ovary, the diagnosis is not so easy. With an examination, by both rectum and vagina, and with the uterine sound, a mistake is apt to be the result of carelessness. Complications are often more difficult to deal with than the original disease. Inflammation, causing fixation of a prolapsed ovary, is one of the chief troubles. Can such cases be cured? I never promise to do more than relieve symptoms. The more recent the disease, the more easy to effect a cure. It is probable that the patient can be cured. I have known cures to follow the use of pessaries for ten years. A pessary should be used in such a way as not to be painful. Always readjust them until this result is accomplished. It should be removed once a year in any case. Take a simple case of retroverted uterus, with more or less dysmenorrhea, backache, stomach disturbance, pain under the left breast, and enlarged uterus, in a woman who has borne children—how shall we replace the uterus? Press the cervix back with one hand, or finger, and through the abdominal wall press the fundus forward. This may seem difficult, but it is often readily done, except in nulliparæ, or in a patient with a very thick and rigid abdominal wall. If you fail, put the patient in the knee-elbow position; introduce a Sim's speculum, draw the cervix down with a tenaculum, and, passing a uterine sound, carry the fundus over and forward. Formerly, before we knew of salpyngitis, etc., pelvic abscesses and similar complications often happened as a result of introducing the sound. I remember a case that I had twenty years ago, in which there was a bad inflammation, as the result of passing a sound into the uterus. Now-a-days, when we have a history of pelvic inflammation, or abscess, or tenderness about the uterus, we know that we are not warranted in introducing the sound. It is liable to cause contraction of the uterus, fallopian tubes, etc., and thus, if any pus be present, forces it out into the abdominal cavity. After replacing the uterus, it is a grave question whether we should at once put in a pessary. It seems much better to wait, and pushing the cervix well back insert a glycerine tampon. I have learned from experience that the utero-sacral ligaments are often very sensitive, even to the finger, and a pessary irritates them. The application of tampons for two or three weeks to the post-cervical pouch enables the patient to wear a pessary comfortably. I am fully convinced that the uterus must be replaced far enough forward to know that the intestines press on the back of the fundus. If this is not done, do not use a pessary. If you cannot get the uterus so far forward, relief is only to be found in surgical interference. As Emmet has aptly said, it is folly to have a regulation standard pessary for all cases, just as much as it would be absurd to have one splint to fit all fractured limbs. Here is a sample taken at random from a collection of forty dozen pessaries that I have. The vagina is really three-cornered; it measures about three inches from side to side at the cervix, about half an inch at the opening and probably about half an inch in its antero-posterior diameter at the cervix. One must have a mechanical eye to succeed in treating these cases with a pessary. Generally, a pessary needs moulding to fit any given case. The Hodge lever pessary, with its modifications, is my favorite. When placed behind the cervix, the long lever rests on the anterior vaginal wall, and the short one back of the cervix. I find that I am sometimes forced to make three or four different efforts before being able to get a pessary properly fitted —that is, a trial at three or four different visits of the patient. In some cases, the uterus bends in such a way that I find it necessary to use a stem pessary

for two or three months. This is a heterodox treatment, but I have never had anything but good results from its use.

CALIFORNIA ACADEMY OF MEDICINE.

Regular Meeting, March 21, 1896.

The President, J. M. WILLIAMSON, M.D., in the Chair.

DR. DUDLEY TAIT read a paper entitled "A Case of Brain Tumor—Operation," which was accompanied by a review of the case from a medical standpoint by **DR. ALBERT ABRAMS** [published at p. 372]. The specimen was exhibited.

DR. D. D. CROWLEY, of Oakland: There are several points for and against operation in such cases. Two years ago a case came under my care where the power of speech was lessened. An operation was deemed advisable, and the skull was trephined. There was nothing found, and, inadvertently, the dura was cut by the trephine. The speech returned for four or five days and gradually left again. The patient could think out things but could not speak. The wound was curetted and the patient recovered his speech gradually, as he had lost it, and spoke better than he ever had before. For two months he had no convulsions, whereas, formerly, he had had two a week. At that time I left for Europe and lost track of my patient, though I heard that he had several convulsions during my absence. Lately a case of epilepsy, with convulsions every few days, especially near the menstrual periods, came under my care. The ovaries were found greatly irritated and were removed; the convulsions were as frequent, and, if possible, more so than before. They may, however, cease in the course of three or four months. Another case, some 8 or 10 years ago, where a compound fracture of the skull existed, with loss of one or two drachms of the brain substance, ended fatally in a peculiar way, 40 days after the accident. I was washing out the wound with a weak carbolic solution, and not a very powerful stream, when the patient went into convulsions and died. As to epilepsy, we do not know as yet that any operation is curative. This case is an interesting one and a brilliant one, from the physician's standpoint, on account of the diagnosis, which pointed out the exact point for the surgeon to work upon.

DR. W. WATT KERR asked if Dr. Crowly had reference to jacksonian or general epilepsy.

DR. CROWLEY: I had deviated somewhat from the subject. General epilepsy was meant.

DR. KERR: In general epilepsy, we do not look for much help. Any operation or shock will, in many instances, alleviate the condition for a time, perhaps a year, but the convulsions will almost invariably return. In general epilepsy, we would not recommend any operative procedure; but in jacksonian, we can be safe in so doing. We cannot promise the patient a cure from such an operation. We know there is a local cause, and the operation may or may not cure. If, in this case, the tumors could have been removed, there might have been a return. Where the irritant can be removed entirely, we can look for a cure, but not if the pressure lasts long enough to set up a degeneration of the nerves.

DR. K. PISCHL: From the ophthalmologist's standpoint, this is an interesting case, in that one month previous to the operation an opthalmoscopic examination was negative. We are led to believe that in brain tumors, we have a choked disc, and that if no choked disc is formed, no tumor exists.

DR. G. GROSS: There is one point wherever specific causes are suspected. We have better means at hand now than inunctions as suggested. With massive injections of calomel, intra-muscular, within one week results begin to show themselves.

DR. TAIT: Regarding the hemorrhage, it was severe, especially from the cortex and dura, the bleeding was in the so-called capsule of the tumor. There was a sudden oozing all around and from the tumor. The sinus was found intact at the necropsy, so the bleeding did not come from there. Where it was adherent to the median line, the connection was quite vascular. As to the probability of recurrence *in situ*, as spoken of by Dr. Kerr, it would have been well to have had the dense connective tissue around the tumor examined histologically, to determine if any sarcoma cells were present there or in the subjacent brain tissue. This case is not presented as illustrating the treatment of epilepsy; jacksonian epilepsy is symptomatic. According to Starr, who has tabulated 600 cases, only 7 per cent. of intra-cranial tumors can be suitably attacked by surgeons for radical relief. There are undoubtedly many more in which relief of pressure symptoms, by what Weir has called "relief opening," can be obtained. In the opinion of Dr. Tait, in all cases presenting signs and symptoms of brain tumor, with such symptoms as indicate that the location is cortical or near the cortex of the hemisphere, trephining is indicated, whatever be the pathologic nature of the tumor—tubercular, cancerous, syphilitic, or parasitic—exploration may be not only advisable but needful. Distinctly multi-tubercular gummata should necessarily be regarded as contra-indicating surgical interference. It is, moreover, not advisable nor prudent to insist too long on anti-syphilitic treatment; three weeks should suffice to clear up all possible doubt as to the curability of the lesions by medical means. In reply to Dr. Gross, regarding specific treatment as a diagnostic agent, I would go one step further and use intravenous injections of sublimate as being still more rapid than the methods he speaks of. The situation of the tumor explains the absence of ophthalmoscopic signs.

Dr. A. L. Lengfeld read a paper on "Aseptolin" [published at p. 377].

Dr. Washington Dodge: I have tried the aseptolin, both as prepared by Lengfeld and by Edson. I have tried it in a number of cases under observation at the Polyclinic that had been under a routine treatment from two to eight months with creasote, etc. After the demonstration of tubercle bacilli in the sputum they were put upon aseptolin, but without the inhalations of iodoform. As I wanted to report the results to the State Medical Society, I wrote to Dr. Edson telling him of my plans, etc., and asking for any further information on the subject that he could give me. He replied that inasmuch as I was using the aseptolin "Lengfeld," that the results, be they as they may, should be credited to Lengfeld's aseptolin, and not to his. His letter was, indeed, interesting and amusing. After using Lengfeld's aseptolin for 18 days, the sputum was examined with seemingly no diminution of bacilli, and in four cases Dr. Ryfkogle found an increase. Those patients losing flesh, went on losing; and two or three went on still more rapidly. Two or three out of the twelve said that their cough was more loose; two slept better and expectorated better, and in two the appetite was improved. I might say that no encouragement was held out to the patients, and no remarks were made to make them hope for a cure. The results in the past 14 days have been negative. Edson says that the bacilli diminish after a week. Such were not my results. Some aseptolin was secured from Edson direct, and, in some 8 days now, no difference has been noted. My impression is that his is the same as Lengfeld's, and that the results are the same. The apparent attempt is to throw mysticism about it all. Dr. Edson has often said that it could not be prepared outside of his laboratory. The only bad results seen were in a young boy, to whom 2 drachms were given, which set up violent nausea, and for four or five mornings vomiting. The injections were stopped till the boy was better, when, upon renewing them, the same symptoms set in, and it was dropped entirely. The smallest dose I have used has been 2 drachms, and the largest 150 minims. The one patient who seemed and said he was better, said he seemed saturated with carbolic acid, but he had been taking 5 drops of creasote for a long time.

Dr W. Watt Kerr: There is evidently a company trying to get a corner on aseptolin. Three weeks ago an *Examiner* reporter asked for the results in the City and County Hospital, and I told him if he would withhold my name, I was perfectly willing to tell him. This he did. He also asked me if Lengfeld's aseptolin was the same as Edson's. I told him that if Edson's formula was true, I could not see why Lengfeld's was not the same, as Lengfeld was a capable chemist. He then pulled out a telegram from Edson saying that it could not be made outside his laboratory. I produced a letter written to me ten days before the telegram stating that a company had been formed in New York to manufacture aseptolin, and its advertisement would shortly appear. This is worse for the integrity of Edson. We have little to expect from aseptolin. My experience has been at the County Hospital, not with private patients; and there at the hospital I did not urge it, just let the patients have it if they wanted to. For a week careful charts were kept, and the weight taken of a number of cases. Bacilli were present in sputum. At the start most patients claimed that they were better, but all consumptives do that with any new drug. As to weight, it remained about the same; although one patient lost 5 pounds. One who has had hemorrhages still has them, and one who never had a hemorrhage previous to treatment, had a severe one. The expectoration in some was easier, they claimed, but I could not note any change in the physical signs. In two wards I used Lengfeld's; in one ward Edson's. The only death occurred in the ward where I was using Edson's, but it was not due to the aseptolin. In reading the report of Edson in the *Medical Record*, it shows that from a clinical standpoint he is insincere. He states that he was led to experiment by noting the immunity to some diseases enjoyed by horses, and thought that phenol was nature's antiseptic, and that if he could introduce it in some amounts strong enough to kill the bacteria he would have a cure for tuberculosis. He goes on with its preparation and back to the clinical standpoint. He said he used pilocarpin, as it increased the leucocytes and made expectoration easier. Now, we know by demonstration in the laboratory that, to be germicidal, phenol must be in a strength of 1 to 100, which would be fatal in the blood. He says he will give sufficient phenol to kill the bacilli, and then turns around and gives pilocarpin. It will all wind up in a fizzle.

Dr. D. D. Crowley: I have used Edson's aseptolin in six or seven cases, and cannot agree with Dr. Kerr as to the results. The preparation has really some beneficial action on the patients; they do well on it, expectoration is easier and pain ceases. This has been specially well marked in a case of tuberculosis of the larynx, where the pain was terrible; aseptolin stopped it. In every instance the cough was stopped or benefited, and the sweats too; the appetite also improved. What will be the ultimate result? Well, it may prolong life for a time, but it will never cure. The iodoform and ether I cannot use, as it clogs the spray tube.

Dr. G. Gross: I tried it in one case, that of a woman; she became worse, and a cloud appeared in the urine, when I stopped it. The spray is a failure in my hands.

Dr. K. Pischl: I have had no experience with aseptolin. We should thank Dr. Lengfeld for his valuable paper and the information presented here to-night.

Dr. Kerr: We are not to look on this preparation, as it is put before us by Edson, as a germicide, but for the action of pilocarpin, which would ease the cough and throat, and Dr. Crowley's cases just bear this out. I think pilocarpin will frequently check night sweats; it is a stimulant to the respiratory center and relieves dyspepsia.

The President: Has any one present used aseptolin in malaria, as it is recommended?

Dr. Kerr: One malarial phthisical case from Fresno was treated by quinine, which was keeping the temperature down; when put on aseptolin he grew worse, so it was stopped.

Dr. Lengfeld: I hesitated to bring this paper here to-night, as it was more of a chemical than of a clinical nature. But I felt so strongly that if Dr. Edson's formula was so wrong chemically there must be something wrong clinically. I firmly believe, that as published first by Dr. Edson it was correct, but that after this, friends and acquaintances got after him to get it up as a proprietary medicine, and he could not withstand the temptation. The letters written to Dr. Dodge and myself by Dr. Edson certainly need some explanation. When I first began working on this formula, I soon found that something was wrong, and on writing to Dr. Edson asking for further particulars as to its manufacture, etc., as I was dissatisfied with my attempts, he said that he was not surprised; that the formula was correct, but that pure phenol and great care and costly apparatus should be used, and that the aseptolin should be perfectly clear, but on examining his product it was not found perfectly clear and free from specks. He may, however, have improved on it since then. Now, if the formula was a complicated one, I could readily see how he, with every practical convenience, could secure better, or the best results; but it is a simple formula, and no more or less difficult than many prescriptions prescribed by physicians every day.

Gangrene of Peritoneum Following Operation for Appendicitis, Discovered Through a Sponge Having Been Left in the Abdomen.—Dr. Dudley Tait

spoke of a case of appendicitis, which had developed very rapidly within forty-eight hours, and which was operated upon. The appendix was found behind the head of the colon, and was tied off with its mesentery and removed. The abdominal wall to the right and two inches above was much congested; it was deemed advisable to pack the lower third of the wound. After the operation, the temperature rose no higher than 99.5° F. Two days after, it was found that of seven sponges that had gone up to the operating-room, only six could be found. Search was made and the sponge could not be found. That afternoon, two hours afterward, there was a rise in the temperature. The abdomen was opened and the sponge found two inches to the left, quite adherent to the intestine. The congested area on the peritoneum was above and to the right and left; all this was gangrenous, and deep down there was a gangrenous hue and a bad odor. The patient owed his life to this sponge having been left in the abdomen, for no one could tell of the impending gangrene, and if the abdomen had not been opened again the patient would have died.

SAN FRANCISCO MEDICO-CHIRURGICAL SOCIETY.

Regular Meeting, April 6, 1896.

A. E. BRUNE, M.D., Vice-President, in the Chair.

DR. EMMET RIXFORD read a paper entitled "Pylorectomy for Carcinoma with Gastro-enterostomy; Report of a Successful Case." [To be published.]

DR. L. C. LANE: I have not had much experience with the special operation considered in the paper, though I have operated on cancer of the stomach a number of times, the first time about twenty years ago. The tumor was situated on the anterior wall, much nearer the cardiac end of the stomach than the pylorus: a somewhat unusual condition. Von Winiwarter, from Rokitanski's autopsies, determined that about 60 per cent. of all carcinomata of the stomach occur at the pylorus. I operated without much instruction, beginning by pouring into the stomach a solution of bicarbonate of potash and washing out the organ. I made the incision in the median line, preparatory to making the section through the stomach; tied the gastric artery and another which led into the region of the disease. There was a good deal of difficulty in finding and isolating these arteries, but when the ligatures had been applied, I worked in almost exsanguine tissue. There was no difficulty in removing the tumor and in uniting the edges of the stomach wound, which was purposely made spindle-shaped. The man lived some three days. A number of operations have been done in this city on the pylorus, but I know of no case in which the patient recovered.

DR. C. N. ELLINWOOD: I have very little to add to the report as made by Dr. Rixford, but it seems to me that he has omitted to describe the picture of the woman before the operation. She was emaciated to a severe degree, sallow in color, and evidently rapidly failing from starvation. She was ravenously hungry, but food only served to increase her discomfort. She would frequently have periods of vomiting, in which large quantities of sour, fermenting material were ejected. Constipation was obstinate. On examining the tumor, after removal, it was found that the canal was closed so as to barely admit a number nine sound. No one can hope for success in such an operation without fulfilling the superlative exactions of ideal asepsis. A case was reported in the *Medical Record*, not more than two or three weeks ago, of excision of the pylorus for a fibroid tumor, by a Dr. Everet. He said that in making the anastomosis between the divided end of the duodenum and the stomach, he occupied but five minutes. This I can hardly think possible.

DR. A. E. BRUNE said not long ago **DR. T. W. HUNTINGTON**, of Sacramento, operated on the pylorus for stenosis, with success.

DR. GEO. B. SOMERS said the operation referred to by Dr. Brune was Loreta's operation of dilatation of the pylorus from within the stomach, an entirely different procedure from excision of the pylorus. He had witnessed but one operation of pylorectomy, and in it immense difficulties were encountered. The omental tissue was so friable that the slightest touch caused it to bleed. It could only be penetrated by placing double ligatures and incising with the actual cautery. In these operations it is difficult to prevent soiling of the peritoneum with intestinal and gastric contents. Dr. Rixford spoke of finding the upper end of the jejunum by lifting up the omentum and exposing the transverse meso-colon to the point where the duodenum passes through it. Of course, where this can be done, it is a certain method of identifying the upper end of the gut, but sometimes, because of adhesions or other circumstances, this is very difficult or impossible. He had seen it stated that if six inches or so of the intestine be lifted up, so as to present a straight line vertically through the wound, and the hand be now passed down following the mesentery, the hand will remain on the same side of the gut, if the proximal end of the gut points toward the head, but it will pass to the opposite side, following the twist of the mesentery, if the distal end is above.

Dr. Henry Gibbons, Jr., said that some months after Murphy's button was given to the profession, Dr. Barbat, of this city, had reported a case of carcimona of the stomach, in which a gastro-enterostomy had been successfully performed by means of Murphy's button.

Dr. W. F. Thomas said he had seen the patient referred to in the paper, sometime before the operation. He had made the diagnosis of cancer of the pylorus, and advised against operation, because the percentage of recoveries after such operations is so small. He wished to know if a microscopical examination had been made of the tumor. The success of the operation cast some doubt on the supposition of malignancy.

Dr. A. W. Perry suggested that since there had been reported a number of cases of operations on the stomach with Murphy's button, in which the button had dropped into the stomach, it would be a possible solution of the difficulty if the buttons were made of pure iron, very thin, which would, in time, be completely dissolved by the gastric juice, and with no particular discomfort to the patient.

Dr. Rixford said it was probable that there was less liability of the button dropping into the stomach after a posterior gastro-enterostomy than an anterior, though it had not been definitely determined. At any rate, in this case it is not certain that the button is in the stomach, the button simply has not been found. A metallic sound was passed into the stomach but no hard body was met with. The patient has not had a single symptom referable to the stomach, and, therefore, search for it by operative methods is scarcely justifiable. As for the microscopical examination of the tumor, of course it will be made, though there is no doubt as to its nature.

Blue Urine.—**Dr L. C. Lane** presented a bottle of deep-blue fluid, saying that he had been consulted that afternoon by a man from Oregon, who gave a history of prostatic enlargement. The man had passed this blue fluid from his bladder a few hours previously. He was taking a deep-blue or black powder in capsules, which had been prescribed by some doctor.

Dr. F. A. Grazer suggested that probably the dark powder was methyl-blue, which is sometimes given internally, and which is excreted by the kidneys. It is recommended in malaria. If this urine contained methyl-blue it could be exposed to sunlight, and, in a short time, the blue color would fade materially.

Regular Meeting, May 4, 1896.

C. N. ELLINWOOD, M.D., in the chair.

Election of Officers.—The following were elected officers for the ensuing half year:

President	A. E. BRUNE
Vice-President	G. W. BURK
Committee of Management	GEO. E. BUSHNELL, F. B. CARPENTER
Secretary	C. F. GRIFFIN

Dr. A. W. Perry read a paper entitled "Cardiac Dyspnea and Cardiac Asthma."

Dr. Albert Abrams: Cardiac asthma has of late assumed much importance. We have always been taught that the dyspnea associated with cardiac disease owed its origin to a congestion of the capillaries of the lung alveoli, which in turn compressed the latter, thus diminishing the volume of air in the lungs. This theory was demonstrated as wrong by von Basch. An increase in the quantity of blood in the capillaries of the lungs caused the lungs to swell and become rigid, and the volume of air in the lungs was increased rather than diminished. The lungs approach the condition of permanent inspiration, and the amplitude of the respiratory excursions becomes lessened. This condition of lung swelling and rigidity can result from an increased or diminished pressure of blood in the aorta. In both instances the final result was the same, viz: congestion of the lung capillaries. The cardiac asthma of cirrhosis of the kidneys and arterio-sclerosis were examples of increased blood pressure, whereas insufficiency of the heart was a paradigm of diminished aortic blood pressure. Dr. Perry did not make any distinction between paretic and spasmodic cardiac asthma, a distinction which was of great value therapeutically. In the former variety the left ventricle was dilated, and in the spasmodic form it was not. The differential diagnosis of bronchial and cardiac asthma was not always easy. It was well to remember that in bronchial asthma the dyspnea was expiratory, whereas in cardiac asthma it was mixed, being both inspiratory and expiratory. Percussion was of less value than auscultation in differentiation. In bronchial asthma sibilant and sonorous rules were always heard, especially during expiration. These rules were absent in asthma of cardiac origin, unless the latter was complicated by edema of the lungs. The speaker could not reconcile the cases quoted by the essayist with the typical picture of cardiac asthma, as the lung swelling which was so essential in the symptomatic complex was absent in both cases; at any rate, the reader of the paper did not give sufficient prominence to this manifestation. The indications given for the administration of morphine in cardiac asthma might prove of some value, but speaking for himself, he knew of only one way of testing the value of a drug in cardiac affections, and that was to try it on the patient. He was heartily tired of constantly reading about the indications for the administration of digitalis in valvular lesions of the heart; all theory was illusory when compared to the simple and practical test of trying the drug on the patient. In this connection he wished to refer to a form of dyspnea produced by irritation of the trigeminal endings in the mucosa of the nose. He could produce an acute dilatation of the lungs in any normal individual by irritation of the nasal mucous membrane. He had extended his investigations by animal experimentation. He believed that his researches were the first demonstration of the production of a lung neurosis by direct irritation of the nasal mucosa. His observations on this subject were embodied in a recent paper before "The Medical Society of the State of California."

Dr. C. N. Ellinwood said he had generally found relief in cardiac dyspnea, from morphine, and occasionally he had used nitro-glycerine with benefit. However, he had used both drugs purely empirically.

Dr. Perry referred to a patient with hydrothorax and resulting dyspnea. The dyspnea was relieved by drawing off the water from the pleura three times and returned only when the cavity had again filled with fluid; but the fourth time the dyspnea returned after 6 hours, long before any considerable amount of fluid could be thrown out. This dyspnea was due to lung rigidity. Nitroglycerine relieved it somewhat, and morphine relieved it for 3 days. In another case, there was retraction of the intercostal spaces and severe dyspnea. The veins were collapsed so that there was evidently no relative incompetency of the tricuspid valve.

Dr. L. C. Lane said that dyspnea might have some explanation on purely physical grounds, *e. g.*, in the lung there are an infinite number of minute blood vessels, capable of elongation. It is a well known principle in physics, that if a tube of given caliber be elongated, the caliber remaining the same, other things being equal, only about half as much fluid will pass through it. In asthma and dyspnea such a condition obtains. But there is another factor in the lung; the vessel in the progress of elongation, becomes diminished in caliber. Now, if a tube of given length and caliber be diminished one-half in diameter, and increased to double its length, it will carry only one-sixteenth its normal quantity of fluid. It is probable, also, that the same law would apply to the air tubes in the lung, and the amount of air reaching the blood is diminished as well as the amount of blood passing through the lung. By reasoning on these lines may be found an explanation of many phenomena of dyspnea.

Dr. G. F. Hanson said the good effect of nitro-glycerine is due partly to the fact that by it the peripheral blood vessels are dilated and those in the brain also, so that the respiratory and other centers receive an increased blood supply.

SPECIAL CORRESPONDENCE.

PARIS.

[FROM OUR OWN CORRESPONDENT.]

Insubordination amongst Hospital Dressers.—Hospital Reforms.—Diagnosis by Photograph.

M. Péyron, the Director of the Assistance Publique, certainly has not a dull life, thanks to the ebulition in the ranks of the medical hierarchy and of their subordinates, the hospital dressers. On the other hand it may be asked if he has a merry one. Occupation may be an antidote to dulness, but it is not always a successful recipe to secure a happy or contented mind. At the opening of the winter session the disturbance was at its height, for reasons which I partially gave in my last letter. The hospital dressers were moved to ire, expressed in the greatest violence, because a privilege many thought they never ought to have had—an allowance of twenty cents a day—had been abolished by the Assistance Publique. This suppression, however, only served to show what that body would like to do, but by no means what it can do. The medical students, dressers, and house surgeons, and students who have no intention of being either one or the other, made common cause, smashed the furniture in the building of the Assistance Publique, held meetings and kept the police on the alert to prevent riots and disturbances on the boulevards in the students' quarter. These representatives of law and order went on duty in twos and threes in the neighborhood of the Medical School and Faculty. The students were prevented from assembling in groups here or on the boulevards, where they resort to restaurants for meals, as well as to drink, gossip, and play dominos. They had the good sense to be as peaceful as other citizens, and the unusual number of police on duty in the students' quarter left nothing for their idle hands to do. Notwithstanding, the students elsewhere were neither peaceful nor idle, and proved themselves to be a power that counts. They held meetings, dictated terms that were accepted, and they now receive their pay as in former times. How long this unsatisfactory state of things will last is a question, but it is one that some day must be seriously grappled with. Indeed, the spectacle of the Dean of the Medical Faculty soothing and calming their overwrought nerves, was a distressing if not a ridiculous exhibition; still it was the best that could be done. It was natural that the Dean of the Paris Medical Faculty should treat with the head of the Assistance Publique, but it is to be regretted that another attitude was not adopted by the representatives of such influential bodies. Truthfully it must be said, the resemblance between them and nurses that have been frightened by the clamor of their charges, were striking. In such cases the nurses earnestly strive to sooth their nurslings and to restore calm, eventually according a passive or positive concession. In the medical students' case it was a positive concession which they noisily and insolently claimed, and eventually attained. The same unwise comedy was played at the Municipal Council. The students sent a deputation to that body, and were received by M. Strauss, one of the members. The Director of the Assistance Publique, in his message to the hospital dressers, said, that in consideration of the intercession of the Municipal Council in their behalf, their pay would not be withdrawn. For the moment these riotous youths carried all before them, but a voice has been heard and this voice has been echoed. During the discussion at the Municipal Council on the pay of the hospital dressers, a member wisely asked, "Why are there hospital dressers?" Dr. Lutaud, in the *Journal de Medicine*, warns these discontented and far from disinterested consolers of the sick, that they are unwise in attracting so much attention, and that their notoriety may lead to their suppression. Certainly the question of the Municipal Council will one day be answered, and it may be to the detriment of the hospital dressers who seek to increase their pocket money whilst they add to their knowledge of practical medicine

The question of hospital circumscription which obliges the indigent sick to be treated in their District Hospital has been modified. The system did not work very satisfactorily. Some hospitals were empty whilst others were overcrowded, necessitating the use of temporary beds. According to the changes ordered in this regulation patients can go to any hospital they wish by appealing directly to the Director of the Assistance Publique, or by requesting the doctor to do so. Concessions have also been made to the Chiefs of Service, who are allowed to see other patients who wish to consult them as out-patients. A great many *soi-disant* reforms have been made, but still complaint has not been silenced. Dr. Bruneville, Hospital Surgeon and Agrégé, at the Paris Medical Faculty, has stated that, except during the hours of the clinique, the hospital wards are not sufficiently cared for. Frequently in cases of accidents there are none to be found capable of attending to the sufferer. Dr. Bruneville has frequently demanded a special emergency service for accidents such as exist in America.

The new photography with the Roentgen Rays, as applied to surgery, is creating a great sensation here. Prof. Lannelongue, a member of the French Institute, has made some successful pictures of surgical affections. One of a case of osteomyelitis so clearly represented the lesion that it was easy to see that the destruction of the osseous tissue proceeded from the center to the periphery, and, as the doctor had previously asserted, basing his belief on his researches. A tuberculous infection in a child's finger was photographed, and was equally instructive. It was observed that the first phalanx was larger than the other fingers; there was thickening of the periosteum, and the effusion from the fungated growth surrounded the osseous tissue. The second phalanx was more transparent than the other, and was probably the focus of an early stage of the osteitis. These revelations confirmed the diagnosis previously made.

PARIS, April 5, 1896.

REVIEWS AND NOTICES.

ANNUAL OF THE UNIVERSAL MEDICAL SCIENCES (eighth year); issue of 1895. Philadelphia: The F. A. Davis Co.

The eighth issue of the "Annual" fully maintains the standard set by its predecessors. The editor, Dr. Sajous, again apologizes for its rather tardy appearance, which, however, is earlier than on several previous occasions. Special attention is directed to the articles on diseases of the lungs and pleura, by Professor Wilson and Dr. Eshner, of Philadelphia; a review of diseases of the spinal cord, by Professor Obersteiner, of Vienna, and one upon diseases of the stomach, liver, and pancreas, by Professor Rubino, of Naples. The article on general therapeutics and pharmaceutical chemistry possesses a special though mournful interest, having been prepared under the direction of Dujardin-Beaumetz. There are many excellent illustrations throughout the five volumes, a number being colored plates of the highest order. A cursory examination of the text shows, that current medical literature has been very thoroughly reviewed.

THE INTERNATIONAL MEDICAL ANNUAL AND PRACTITIONER'S INDEX FOR 1896. Edited by a corps of thirty-seven department editors—European and American. Illustrated. New York: E. B. Treat. pp. 728. Price, $2.75.

The fourteenth yearly issue of this valuable one-volume reference work is at hand, and richly deserves and perpetuates the reputation which its predecessors have made for selection of material, accuracy of statement, and usefulness. The corps of department editors is representative in every respect. Numerous illustrations, many of which are in colors, make the "Annual" more than ever welcome to the profession, as providing, at a reasonable outlay, the handiest and best yearly resume of medical progress yet offered. Part first, comprises the new remedies, together with an extended review of the therapeutic progress of the year. Part second, includes a number of recent articles by eminent authorities: How to determine the parasite of malaria; the diagnosis of toothache and neuralgia; the remedial value of cycling; sensory distribution of spinal nerve roots; angio neurosis; life insurance, and Roentgen's method of shadow photography, illustrated. Part third, comprising the major portion of the book, is given to the consideration of new treatment; it covers 500 pages, and is a retrospect of the year's medical and surgical progress. The fourth, and last part, is made up of miscellaneous articles, such as recent advances in sanitary science; new inventions in instruments and appliances; books of the year, etc. The arrangement of the work is alphabetical, and, with its complete index, it is a valuable reference book.

A MANUAL OF ANATOMY. By Irving S. Haynes, Ph.B., M.D., Adjunct Professor and Demonstrator of Anatomy in the Medical Department of the New York University; Visiting Surgeon to the Harlem Hospital, etc. With 134 half-tone illustrations and 42 diagrams. Philadelphia: W. B. Saunders, pp. 680. Price, $2 50.

This work on anatomy occurs as one of the excellent series of manuals for students, which are now being issued by Mr. Saunders. It is very attractive in appearance, clearly printed, and finely illustrated with numerous half-tone plates taken from photographs of dissections. The text is well arranged for descriptive purposes, special attention being paid to surface landmarks and to dissection notes. The plan of the work is based on regional anatomy, and students wishing a hand-book of anatomy will make no mistake in procuring it. There is, however, a question as to what position such a book should occupy in the study of anatomy. Students require but two books on anatomy, one a text-book and book of reference; the other, a practical work for use in the dissecting room. It is a bad plan to encourage students to rely on abbreviated works for purposes of study. They are unsatisfactory, for they cannot give full enough descriptions to enable the student to form mental pictures of the parts described. There is no royal road to anatomical knowledge. It can be obtained only by hard work in the dissecting room and within a complete text-book. This manual will find its greatest usefulness in the dissecting room. A word about the plates: Though in themselves admirable and representing very skillful dissections, yet they are not so practical for students as figures, which are more diagrammatic. To save time and mental effort and to avoid confusion of thought, students need to see the meaning of a figure at a glance. Photographs from actual dissections cannot be made to bring out clearly and distinctly many of the more complicated anatomical points. They generally require close study and more or less familiarity with the parts represented. Again, for the sake of clearness and time saving, it is preferable to print names on or near the parts, as is done in some of our best text-books; rather than to refer to foot-notes by means of letters or figures.

MEDICAL NEWS.

LICENTIATES OF THE BOARD OF EXAMINERS.

At a meeting of the Board of Examiners, held April 7, 1896, the following were granted certificates to practise medicine in this State:

Oscar S Brown, Wildomar; Starling Med. Coll., Ohio, Mar. 4,'86.
Wm. H Campbell, San Francisco; Gross Med. Coll., Colo.; April 8,'90.
J. F. Douglas, San Francisco; Bellevue Hosp. Med. Coll., N. Y., Mar. 14,'87.
Frank B. Eaton, Portland, Or.; Med. Coll. Pacific, Cal., Nov.,'75.
John C. Fisher, Lytton Springs; Long Island Coll. Hosp., N. Y., June 22,'76.
J. T. Hartley, Antioch; Miami Med. Coll., Ohio, March 9,'82.
Franthu B. Ives, Pasadena; Rush Med. Coll., Ill., Feb. 7,'50.
E. R Johnstone, San Francisco; Coll. Phys. and Surg., Keokuk, Ia., Mar. 8,'92.
Herbert W. Joyce, San Francisco; Lic Soc. Apothecaries, England, Mar. 13,'93.
Henry S. Kergan, Oakland; Michigan Coll. Med. and Surg., Mich., Mar. 29,'94.
Joseph M. King, San Fernaudo; Coll. Med., Univ, Southern Cal., June 4,'95.
Samuel L. Kistler, Columbus, Ohio; Starling Med. Coll., Ohio, Feb 23,'82.
Norman L. Lee, Junction City, Or.; Med. Dept. Willamette Univ., Or., Mar. 4,'71.
Eugene Mathewson, Bostonia; Gross Med. Coll., Colo., April 12,'94.
A D. McLean, San Francisco. Hosp. Coll. of Med., Ky., June 18,'95.
P. Wm. Nathan, San Francisco; Med. Dept. Univ. City of New York, April 7,'93.
W. F. H. Osmun, San Francisco; Jefferson Med. Coll., Pa. April 3,'89.
Julius Silberstein, Fort Apache, A. T.; St. Louis Coll. Phys. and Surg., Mo., Mar. 10,'91.
Mary E. Stark, Los Angeles; Woman's Med. Coll., N. Y. Infirmary, May 27.'80.
Fred Thompson. Sierra City; Harvard Med. Coll., Mass., June 27,'88.

CHAS. C. WADSWORTH, Secretary.

Official List of Changes in the Stations and Duties of Officers serving in the Medical Department of the U. S. Army (Division of the Pacific) from April 20, 1896, to May 20, 1896.

Captain Guy L. Edie, Assistant Surgeon, will, upon the expiration of his present leave of absence, report for duty at the Presidio of San Francisco, California.

First Lieutenant Powell C. Fauntleroy, Assistant Surgeon, is relieved from duty at Fort Riley, Kansas, and ordered to Fort Grant, Arizona, for duty at that post.

First Lieutenant Benjamin Brooke, Assistant Surgeon, is relieved from further duty at Fort Canby, Washington, and, upon completition of his examination for promotion, will proceed to Fort Thomas, Kentucky, and report for duty at that station.

First Lieutenant John S. Klup, Assistant Surgeon, will proceed at once to Fort Canby, Wash., and report to the commanding officer for temporary duty, relieving Captain William Stephenson, Assistant Surgeon, who will return to his proper station. Par. 4, S. O. 70, Dept. of the Columbia, April 28, 1896

First Lieutenant M. W. Ireland, Assistant Surgeon, assigned to duty with the Yosemite Park Squadron. Par. 1, S. O. 50, Dept of Cal., April 20, 1896.

First Lieutenant Paul Straub, Assistant Surgeon, assigned to duty with the Sequoia Park Squadron. Par. 1, S. O. 50, Dept. of Cal., April 28, 1896.

Official List of Changes of Stations and Duties of Medical Officers of the U. S. Marine Hospital Service (District of the Pacific) from April 20 to May 20, 1896.

John Godfrey, Surgeon, to inspect quarantine ports on the coast of California.

ITEMS.

Dr. A Liliencrantz has removed his office from 819 Market street to 803 Sutter street, San Francisco, Cal.

Dr. B C. Bellamy has removed from 1327 South San Joaquin street, Stockton, Cal., to Livermore, Cal.

Commercialism and Specialism to Date.—The following clipping from a paper in the southern portion of this State is worthy of notice as an example of the enterprise of the medical "rustler" and up to date specialist of to-day: "Drs. X & X. Fees one half the usual rates; prescriptions at the office, 50 cents; visits inside mile square, $1, and each additional mile, 25 cents; general practice, but will give special attention to the lower orifices of the body, both sexes."

C. S. Worden & Co.—At the meeting of the State Society, held in Los Angeles, Messrs. Worden & Co. made an elaborate display. Machinery turning out tablets, pills, etc., was in operation, giving an idea of the manner in which these necessities are manufactured on a large scale. Methods for securing accurate dosage and rapid disintegration were shown, eliciting great admiration. Machines and employes were sent down from San Francisco especially for this occasion. The making and filling of gelatin capsules was very interesting and quite a revelation to most visitors. The inner man was provided for by Malto Fer, both with and without strychnine, and many physicians experiencing "that tired feeling" went away "fully restored."